Health Information Technology Advisory Committee
Interoperability Priorities Standards Task Force
December 11, 2018, 10:00 a.m. - 11:30 a.m.
VIRTUAL

The December 11, 2018, meeting of the Interoperability Standards Priorities (ISP) Task Force (TF) of the Health IT Advisory Committee (HITAC) was called to order at 10:02 am ET by Lauren Richie, Office of the National Coordinator for Health IT (ONC).

ROLL CALL

Members in attendance

Kensaku Kawamoto, co-chair, University of Utah Health
Steven Lane, co-chair, Sutter Health
Clement McDonald, Member, National Library of Medicine
Andrew Truscott, Member, Accenture
Edward Juhn, Member, Blue Shield of California
Leslie Lenert, Member, Medical University of South Carolina
Raj Ratwani, Member, MedStar Health
Ram Sriram, Member, National Institute of Standards and Technology
Ricky Bloomfield, Member, Apple
Sasha TerMaat, Member, Epic
Terrence O'Malley, Member, Massachusetts General Hospital
Tamer Fakhouri, Member, One Medical

Members not in attendance

Arien Malec, Member, Change Healthcare
David McCallie, Jr., Member, Cerner
Ming Jack Po, Member, Google
Cynthia Fisher, Member, WaterRev, LLC
Tina Esposito, Member, Advocate Health Care
Sheryl Turney, Member, Anthem
Scott Weingarten, Member, Cedars-Sinai Health System
Valerie Grey, Member, New York eHealth Collaborative
Victor Lee, Member, Clinical Architecture

ONC Staff

Caroline Coy, Branch Chief, Strategic Initiatives
Farrah Darbouze, Public Health Analyst, ONC ISP Task Force Lead
Lauren Richie, Branch Chief, Coordination, Designated Federal Officer

Laruen Richie called the meeting to order, conducted roll call, and then turned the meeting over to the co-chairs.

Introduction

Ken Kawamoto shared that there are two main agenda items. There will be a presentation on what Fast Healthcare Interoperability Resources (FHIR) could potentially offer to referrals and then there will be a review of the draft recommendations.

He then transitioned to Brett Marquard to review the state of FHIR workflow.

FHIR Presentation - Brett Marquard, Principal, WaveOne Associates

Brett Marquard shared that he spoke with several folks to gain their perspective on FHIR workflow to prepare for today's discussion. FHIR workflow is intended to cover many things and is attempting to do many types of complex coordination across systems; it is much broader than referrals.

FHIR Resources

To support this vision, there are a lot of FHIR resources. Workflows under FHIR include processes that must be coordinated across systems, e.g., orders, referrals, service requests, etc. There are three resource types that are utilized in FHIR workflows:

- Things that are time dependent, like questionnaires
- Requests where someone is being asked to do something specific. The name referrals was recently changed to service requests, making it more generic.
- Events that could relate to a request (e.g., encounter, observation)

There has been talk about workflow within the FHIR community for years, with Lloyd Mackenzie as the lead author. State of FHIR workflow development –identified there is a lot to solve and some of the pieces needed to make this happen. There isn't yet a Workflow Implementation Guide that encompasses how to keep the FHIR resources together.

Opportunities for referrals in FHIR

- 2017 Argonaut effort to develop a Scheduling Implementation Guide, Including the ability to request the available times in a provider's schedule.
- There is an Argonaut Provider Directory Guide, some of the components of which have been picked up by Sequoia and Care*q*uality efforts.
- Clinical dDecision Support (CDS) Hooks, on the edge of FHIR specifications, provides a standard way to implement CDS into a workflow.
- Questionnaire Implementation Guide specifies how to collect additional information from the patient, and how questionnaires can be used by providers to gather additional information.

Common items that should be supported

- Initiate a referral request that includes: patient identifiers, referral identifiers, and clinical information (C-CDA or FHIR resources)
- Receive updates from the external system regarding the status of the referral (e.g., declined, accepted, in progress)

- Initiate a cancelation
- Process completion of referral and corresponding clinical information that goes with the referral

Receiver Referral Requirements

- Receive referral request
- Receive cancel messages
- Sending status
- Sending referral outcomes

FHIR can support these things, as well as other technologies. These capabilities are needed regardless of the underlying technology.

360X utilizes existing standards. It helps move the ball forward, but there are complexities that new folks will have trouble picking up. There is less experience with the use of the components of FHIR workflow, though progress has been made. FHIR is powerful in terms of allowing new entrants and workflows. There is an opportunity to encourage Argonaut or others to do piloting for more learning. Piloting provides a lot of learning and is important in order to identify the requirements for systems.

Discussion

- **Steven Lane** questioned if there are technological limitations that make one technology more optimal than the other.
  - **Brett Marquard** responded that in terms of maturity, 360X is somewhat new and there is limited experience. FHIR workflow could catch-up quickly. The future is moving toward a FHIR-based flexible framework rather than Direct.
  - **Terry O'Malley** commented that it seems that 360X is asking for a new set or capabilities that Direct and FHIR don't currently have. Seem to be asking for a module that will manage the message flow and meet the specifications of the use case.
    - **Brett Marquard** commented that he is confident that a FHIR specification can be written that parallels the 360X specification. Could include specifications within Direct and parallel the 360X flow. It might be worthwhile to spec that out, to push FHIR in a parallel path, or perhaps there is a third path. 360X is a great solution for the current environment, but it is tough to see how additional capabilities will fit into the 360X framework.
  - **Ricky Bloomfield** commented that there has been a lot of technical work, but the key is to identify a narrow use case and parties that are willing to pilot it. It is going to be an iterative process (starting small and simple). There isn't a more complicated area of health IT than workflow management. This is not low hanging fruit.
  - **Steven Lane** asked about timeliness, is one technology more appropriate for something that needs real time back and forth communication of data?
    - **Brett Marquard** commented that the 360X standard should be quick to rollout. While there is support, he is not sure that it is supported well. How well it is supported varies a bit. Brett validated Ricky's comment that starting small is important. Components of 360X are readily available to use, but the support is variable. That specification has more definition than anything else now.

- **Sasha TerMaat** noted that Vassil Peytchev is commenting in the chat. She then shared his comments with the group noting that there is a workflow change in 360X. 360X is also looking at pre-auth workflows.
- **Clem McDonald** asked if there is a short guide about 360X to describe it in more detail that could be shared, it would be appreciated.

- Holly Miller shared in the chat that there will be a white paper available in January.

Steven Lane then transitioned to a review of draft recommendations.

Recommendations

Steve Lane shared that he and Ken Kawamoto will be presenting the draft recommendations to the HITAC on Thursday, December 13, 2018.

Priority 1a: Current referral workflows are inefficient, fail to leverage available interoperability tools, leading to increased cost, delays in care and poor care coordination.

Comments

- **Terry O'Malley** commented that there is a good level of detail that helps connect to potential solutions. He suggested expanding the list of use cases to lab request results or longitudinal care coordination/shared care.
- **Steven Lane** asked if orders and results could be kept separate and simply referenced here as is the task force has already addressed this domain elsewhere.
  - **Clem McDonald** agreed with not adding.
  - **Terry O'Malley** agreed that a reference to the similarity between closed loop referrals and order requests is enough and committed to providing additional language to the group regarding the cross-cutting items.
- **Ken Kawamoto** suggested adding at the bottom with the other cross-cutting items.

Priority 1b: There is no standardization regarding what clinical data should be collected prior to referring a patient to a given specialist for a given problem or symptom.

Comments

- **Tamer Fakhouri** commented that this resonates based on his experience.
- **Clem McDonald** noted that he was concerned that the questions are not quite as specific as they could be. He noted it is a good goal though.

Priority 1c: EHR-integrated solutions for secure clinician-to-clinician patient-specific messaging are lacking, especially when clinicians work in different organizations or with different EHR/HIT systems.

Comments

- **Sasha TerMaat** commented that vendors tend to think about what users have requested and want to be judicious about where additional features will required by regulation. She expressed

concerns that this might not be specific enough. If features need to be required, a prioritized list of items would be needed for vendors to act upon.

- **Steve Lane** commented that vendors will have their own customers who will prioritize other items. The intent is to have broad community input to support recommendations for ONC action.
- **Sasha TerMaat** suggested differentiating those features that need to be required in a certification program because it is important that all systems implement them consistently. There are products that focus on specialties and specific uses, in these cases, there may be different prioritization that certification might preempt. She suggested that there be items that are strongly encouraged versus required.
- **Steve Lane** expressed concern that this task force does not have the time to do this level of prioritization.
- **Sasha TerMaat** suggested editing the language to identify that, in general, the items listed are support and encouraged. If there are items which are in further deliberation determined to be important to be adopted consistently by all systems, that these be prioritized with an awareness that they may preempt user requests.
- **Ricky Bloomfield** supported Sasha's comments, noting the market should figure out what makes sense.

Priority 1d: Referral management and care coordination both require the ability to reliably identify and locate providers and to understand the messaging capabilities of each provider.

Comments

- **Clem McDonald** asked if it could be added to include the national provider identifier (NPI) in provider directories.

Priority 1e: Establishing the required governance for information sharing, enabling referral management, scheduling, etc., takes substantial effort and can be a barrier to closed-loop referrals and care coordination.

Comments

- **Sasha TerMaat** questioned if this recommendation is consistent with the feedback the HITAC Trusted Exchange Framework and Common Agreement (TEFCA) taskforce already provided. That group discussed push messaging, and Sasha was concerned that it wasn't consistent with the recommendations that came out of that taskforce. Sasha committed to reviewing the recommendations for validation.
  - **Sasha TerMaat** followed up and shared that the TEFCA taskforce could not come to a consensus. Based on the recommendations this recommendation would be reasonable in this context.

Priority 2a: Referral management and care coordination currently rely on fax, telephone, and postal mail communication that does not automatically incorporate relevant discrete information into patients' electronic medical records and clinicians' EHR workflows, with resultant process inefficiencies, and increased clinical and privacy risks for patients.

Comments

- No comments to the suggestions were provided by the taskforce.

Priority 2b: Patient-clinician messaging is currently supported principally within EHR-integrated patient portals.

Comments

- No comments to the suggestions were provided by the taskforce.

Priority 2c: Real time text messaging is increasingly being used to support clinical communications both within and between clinical organizations.

Comments

- Clem McDonald expressed concern with wrapping in too many standards. He suggested that it would be nice to just talk and get something done.

Priority 2d: Patient care is fragmented, inefficiencies and redundancies are introduced, and potential patient safety hazards are created due to the lack of coordination between care providers.

Comments

- No comments to the suggestions were provided by the taskforce.

Lauren Richie transitioned to public comment.

Public Comment

There was no public comment.

The following public comments were received in the chat feature of the webinar during the meeting:

Vassil Peytchev: I think there is a different way to look at this. The functionality required for managing closed loop referrals is the maturity that 360X is bringing to implementations. The 360X project is in conversations with payors to add the pre-auth workflows as a consideration. It is not the intent that this part of the workflow will necessarily use Direct/XDM messaging.

Holly Miller, MD: We are planning to write a brief 360X white paper in January

Next Steps

Steven Lane summarized next steps for a couple members:

- Terry O'Malley committed to providing language around the cross-cutting items
- Sasha TerMaat will provide additional language around the vendor specifications and will review the TEFCA recommendations.

He also reminded the taskforce that he and Ken Kawamoto would be presenting to the HITAC on Thursday. He also asked for any additional comments and feedback from the group to be sent via email or comments within the draft recommendations document posted on Google Drive.

Steven Lane then transitioned to the draft orders and results recommendations, noting that there have been some language changes to streamline and two additional recommendations were added based on David McCallie's feedback. The first is related to data provenance, and the other was the need for a digital signature or other functionality to ensure that results information has not been modified or tampered with as it transmits across the system. These updates will be reviewed in more detail during the next meeting. In the interim, the suggested revisions will be posted to the Google Drive and task force members are invited to provide comments.

The next meeting of the ISP TF is currently scheduled for January 8, 2019, at 10:00 am.

The meeting was adjourned at 11:27 a.m. ET