Health IT for the Care Continuum Task Force (HITCC)

Transcript

March 6, 2019

Virtual Meeting

Members/Speakers

Name	Organization	Role
Carolyn Petersen	Individual	Chair
Chris Lehmann	Vanderbilt University Medical Center	Chair
Aaron Miri	University of Texas Austin	Member
Steve Waldren	American Academy of Family Physicians	Member
Susan Kressly	Kressly Pediatrics	Member
Chip Hart	PCC	Member
Lauren Richie	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator for Health Information Technology	HITAC Back Up/Support
Stephanie Lee	Office of the National Coordinator for Health Information Technology	Staff Lead
Samantha Meklir	Office of the National Coordinator for Health Information Technology	SME
Zoe Barber	Office of the National Coordinator for Health Information Technology	Back Up/ Support
Al Taylor	Office of the National Coordinator for Health Information Technology	SME

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Good morning, everyone and welcome to the HITCC, Health Information and Technology Advisory Committee Taskforce for the Health IT for the Care Continuum. A long title there, but this is now the fourth kickoff we've had for the taskforce groups that are charged with providing recommendations to ONC on their proposed rule for the 21st Century Cures Act. We have a full agenda today so we will go ahead and get started with welcome and introductions. But first, we will take roll call. Carolyn Petersen?

Carolyn Petersen – Individual - Co-chair

I'm here. Good morning.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Chris Lehmann?

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Present. Good morning.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Good morning. Aaron Miri?

Aaron Miri – University of Texas at Austin- Member

Good morning.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Good morning. Raj Ratwani? Steve Waldren?

Steve Waldren – American Academy of Family Physicians - Member

Good morning.

Lauren Richie – Office of the National Coordinator for Health Information Technology -

Designated Federal Officer

Hart? I thought I heard Chip dial in. And Susan Kressly?

Susan Kressly – Kressly Pediatrics - Member

I'm present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Okay. With that, I would like to turn it over to our co-chairs, Carolyn Petersen and Chris Lehmann, for a few opening remarks. And then, we'll do a round of introductions.

Carolyn Petersen – Individual - Co-chair

Good morning, everyone. I am so pleased we are able to start convening this task force. This is really, really important work that we have ahead of us. And I am really grateful that you will come and join us and help us to help ONC further the interests of our pediatric patients and their parents and caregivers. Thank you. I really look forward to working with you. Chris?

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Good morning, everybody. I can only echo what Carolyn says. This is important work. This has been work that has been sorely needed. And we're glad we are at the stage. Electronic health records for children for the use of children requires specific functionalities and requirements. And we are glad that not only was this recognized in the 21st Century Cures Act but is now coming to a stage where we will be heading to a voluntary certification. I'm very appreciative of everybody who was on this task force and will help us going in the right direction. Thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Great. So, why don't we start with a round of introductions? I know we have a number of ONC support staff as well as our individual members. So, why don't we start with our actual task force members who are on the line? We've heard from Carolyn and Chris. Aaron, would you like to introduce yourself?

Aaron Miri – University of Texas at Austin- Member

Yeah, I'm on mute. Hello. Can you hear me?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

We can hear you now.

Aaron Miri – University of Texas at Austin- Member

Okay, perfect. Thank you. Hey, this is Aaron Miri. I'm the CIO for the University of Texas at Austin, Dell Medical School, and UT Health Austin. And we have a very large pediatric practice within our facility. So, I look forward to this committee and moving the ball forward.

Thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

And I don't think Raj is on the line yet. Steve?

Steve Waldren – American Academy of Family Physicians - Member

Hi, sorry. I'm used to multiple Steves on meetings anymore. I'm Steve Waldren. I'm Vice President and Chief Medical Informatics Officer at the American Academy of Family Physicians of about 71,000 of our members. Most of those see kids. And I look forward to helping push this along.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Are you on mute maybe, Susan?

Susan Kressly – Kressly Pediatrics - Member

I didn't hear the introduction. Sorry. Sue Kressly. Sue is fine. I'm sort of a three-legged stool in that I still am in private practice outside of Philadelphia, which uses innovative health IT and has since 2004. I also am in some leadership roles at the American Academy of Pediatrics, including our Child Health Informatics Task Force. And I am the medical director of office practicum, which is a pediatric specific electronic health record. And I am really excited that I can pull all of this together so that we can improve the care of our kids. Thanks.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Thank you, Sue. And I do believe we have Chip on the line now.

Chip Hart – PCC - Member

Yeah, I'm here. Sorry about that earlier. And also, Northern Vermont is experiencing a big internet outage. So, who knows? I could even just fall off suddenly. My name is Chip Hart. I work for PCC. I think, Sue, it's fair to say we're the other pediatric EHR vendor in the ambulatory space. We've been in this market for a very, very long time. And some of us go all the way back to CCHIT days of helping create better IT solutions for pediatricians to help take care of kids. So, we're really, really excited to be able to help with this.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Great, thanks. And I'll turn over to our ONC team. Again, I'm Lauren Richie. I'm the designated federal officer for the full HITCC. And I will turn it over to starting with our staff lead, Stephanie Lee.

Stephanie Lee - ONC- Staff Lead

Hi, everyone. My name is Stephanie. I'm the staff lead. I am a policy analyst here at ONC in

the Regulatory Affairs Division. And I'm very excited to work on this task force. Thanks.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Sam?

Samantha Meklir – ONC - SME
Good morning. I'm Samantha or Sam Meklir in the Immediate Office of Policy at ONC and a policy advisor here and very excited to have the opportunity to work with everyone here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Great. Cassandra?

Cassandra Hadley – ONC - HITAC Back Up/Support
Good morning, everyone. I'm Cassandra Hadley. I am the back up and support for the HITCC and the task forces. I'm also a public health analyst here at ONC. Thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
And do we have Zoe on the line?

Zoe Barber – ONC – Back Up/ Support
Yeah, hi, Zoe Barber. I'm a policy advisor in the Regulatory Affairs Division here at ONC. I'll be supporting Sam, Stephanie, and Cassandra.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Anyone else from ONC that I missed?

Al Taylor – ONC - SME
This is Al Taylor. I'm in the Office of Technology at ONC. I provide the technical and interoperability standards advisory support to this effort.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thank you, Al. Anyone else? Okay. I will turn it back to our chairs, Chris and Carolyn.

Carolyn Petersen – Individual - Co-chair
Thanks, Lauren. Could we have the next slide, please? I will now ask our representative from ONC to walk us through the charge.

Samantha Meklir – ONC - SME

Hi, this is Sam. And I hope everyone has the slide in front of them. Does anyone have challenges with web access this morning?

Chip Hart – PCC - Member

Yes, I do, but I've got the slide, so I'm sure I can follow alone.

Samantha Meklir – ONC - SME

You have the decks, okay. So, we'll be sure to tell you the title. This is the Health IT for the Care Continuum Task Force Charge. So, on the top, we have the overarching charge focused on providing recommendations on our approach. Recommendations and the identified 2015 edition certification criteria to support pediatric care and practice settings for later criteria to support multiple care or practice settings. And also, there is a request for information in the care continuum section of the MPRM focused on how health IT can support the treatment and prevention of opioid use disorder. Specifically, we're seeking recommendations on the following. And we broke this out by sub bullets. On later slides, we have some specific targeted questions to help focus these charge elements. I just want to make sure everyone can hear me okay. There's a little bit of feedback.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

We can hear you fine.

Samantha Meklir – ONC - SME

Okay, super. Fabulous. So, there are 10 ONC recommendations to support the voluntary certification of health IT for pediatric care. And we would appreciate review and input on whether any of those 10 recommendations should be removed as a recommendation to include for pediatric health IT voluntary certification criteria. We also identified 2015 edition certification criteria to support the certification of health IT for pediatric care and practice settings. This correlates to the technical worksheets. And we will talk about that. That is also the third bullet. There are specific questions in those technical worksheets, which will align with the charge activities. There are four questions, and there are three that we will highlight and focus on in the slides. So, this part of the charge is really involving working through some of the scoped questions on those worksheets.

We particularly want to call out that we're interested in recommendations that focus on the 2015 edition data segment for privacy and the consent management for API certification criteria. There's existing DS for P, or data segmentation for privacy criteria, in the 2015 edition. And there are also proposals in our rule regarding this standard and also, a fire based API segmentation proposal. This is, we believe, specifically of value and interest to the pediatric and OBYG disorder use case. And so, we wanted to highlight this as part of the charge as there will be targeted questions that align both with the pediatric section of the care continuum in the rule and also the request for information on OBYG disorder prevention and treatment. And then, the last part of this charge really refers to the overall request for information on OBYG disorder and treatment, which is part of, again, the care continuum section.

And we have targeted questions to focus on in other parts of this presentation that we will highlight as well. I'd like to invite Carolyn or Dr. Lehman, Chris, any clarifying comments on the charge?

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Yeah, just one comment. So, this is going to be a little bit of a zigzag for this committee. I think it's very clear that the first two specific charges, they are related. And so are the pediatric technical worksheets. But, again, I think the connection to the data segmentation for privacy is the adolescent population and, again, the need for this specific access to data. So, it kind of falls within the expertise of this committee. As for the opioid use disorder, this group has a lot of expertise when it comes to care of children. I think one of the things that we will focus on, in addition to the treatment and prevention is also the long term follow up of neonatal patients with neonatal abstinence syndrome and long term assessment of outcomes.

So, that kind of falls in there. It's not specifically in there. But I wouldn't be surprised if this group ends up going into this direction. But if you look at it from a holistic point of view, all of these issues fall into the interests of people who take care, in one form or another, of pediatric patients. So, I'm very excited about the composition of this group and love the fact that we have family practice representatives as well as pediatrics and pediatric vendors. Thank you.

Samantha Meklir – ONC - SME

Thank you. Any other clarifying comments or questions on the charge? Chris did reference NAS, and we do have specific questions that align to that topic that we will get to shortly.

Carolyn Petersen – Individual - Co-chair

Okay. Shall we move to the next slide?

Samantha Meklir – ONC - SME

Okay. Thank you. I think what I'd like to do, this slide and the next slide provide some key content and overview on health IT for pediatric care in practice settings. This is information we also have available on our website. What I'd like to do is as background we provided the preamble to the rule, health IT for care continuum. I'd like to take a minute or two to walk through some of the key content in that preamble, and then, we can circle back to these slides that provide a good summary and overview. So, Section 4001.B.1 of the Cares Act instructs the national coordinator to encourage, keep, or recognize through existing authorities the voluntary certification of health IT under the program for use in medical specialties and sites of service for which no such technology is available or where more technological advancement or integration is needed.

Our approach for addressing this breaks into three parts. First, ONC analyzes existing certification criteria to identify how such criteria may be applicable for medical specialties and sites of service. Second, we focus on the real time evaluation of existing and emerging standards to determine applicability to medical specialties and sites of service, as well as to the broader care continuum, including the evaluation of such standards for inclusion and the

ONC interoperability standards advisory. And third, we may work in collaboration with stakeholders to support the development of informational resources for medical specialties and sites of service for which ONC identifies a need to advance the effective implementation of certified health IT.

For health IT for pediatric settings located in Section 4000.B.3 of the Cares Act, health information technology for pediatrics lays out certain requirements the second of which indicates that the secretary shall adopt certification criteria to support the voluntary certification of health IT for use by pediatric health providers to support the healthcare of children. So, circling back to the slide that we now have in front of us, in response to this, ONC has developed 10 recommendations for the voluntary certification of health IT for pediatric care. This does not include creating a separate certification program for pediatric care in practice settings. We identified how these recommendations are supported by current and proposed new certification criteria that can support pediatric care in practice settings.

And we also focus on nonregulatory initiatives that are nimble and responsive for stakeholders, including the development of informational resources that can support this setting specifically. Let's go to the next slide. Okay. This is an infographic that we also have available on our website. If you click into it, part of it will enable you to access other key information. What you see here are the 10 ONC recommendations for pediatric health IT for voluntary certification criteria. And then, on the bottom, you'll see the summative listing of where we believe the 2015 edition criteria supports crosswalks and aligns with recommendations and where we have proposed new edition criteria that also could support these priorities for the effective use of health IT in practice to execute these priorities in practice. On the very top, you can click on and access the children's EHR format.

Information on the format was included as part of a background document for the committee where we lay out some of the history and background of the children's EHR format as it involved our federal colleagues at CMS, AHRQ, HRSA, the leadership of key stake holders throughout the years. And we also describe, in the preamble, more of the history and background in how this work has very much been informed and build upon a lot of the work that's gone into identifying those priorities over the years. Let me pause for questions or clarifying comments from the chair or co-chair for this slide.

Carolyn Petersen – Individual - Co-chair

I don't have any. Thank you.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

I just wanted to say how excited I am to see these recommendations. A lot of this work has been conducted in the context of building the model EHR format and then, fine tuning it. and I'm very excited to see, coming from ONC, these recommendations that in the past have been perceived as high value for pediatrics.

Samantha Meklir – ONC - SME

Thank you. Can we move to the next slide? Okay. What I'd like to do is provide an

organizational overview of the pediatric technical worksheets. And then, we'll turn this over to Dr. Lehman, Chris, to walk through each recommendation. He'll describe the specific recommendation. He'll describe the functionality intent providing context and background. And then, Al Taylor, Dr. Taylor, part of the ONC team, will specifically talk through where that recommendation is supported by 2015 edition criteria and where we believe it is supported by what we propose in this rule. In other words, the crosswalk of relevant criteria to support that priority in action. So, the technical worksheets, I'm not sure if we're able to real time click into this document and scroll throughout. If that's possible, super, wonderful. So, this is a document that is in the appendix of the rule that is accessible on ONC's website.

It was also attached as a separate PDF document. This will really be very useful for the work of this committee. What you'll see here is, in the beginning, there are four overarching questions. Let's circle back to those questions after we go to the first recommendation so we can see how we lay this out. And then, we can go back and focus on what we were asking, particularly as it aligns to what's in the charge. So, if we can scroll down to Recommendation 1. I'm just going to take a minute to identify how this is organized from a content perspective. First, we list the priority. Then, below, again, we identify where it aligns with the children's EHR format and a description of the functionality intent as aligned with that from the format description. And then, what you'll see is where we believe this recommendation is supported by the 2015 edition and the criteria that are relevant for that recommendation.

And then, if you scroll down a little bit more, you'll see where, again, we think that it aligns with proposed new or updated certification criteria based on what is in this rule. For I think it's the first five or six recommendations, towards the end you'll note we include supplemental children's format requirements. And here, we include – we're basically asking how these may be relevant to potentially be correlated to Recommendation 1. That is the context for why they are included. Let's circle back now to the top of the pediatric technical worksheet where we have the four overarching questions. Great. So, I'd like to focus on Question 3 and Question 4. These we envision that the worker will be able to provide concise, clear recommendations here, particularly for No. 3, should any of the 10 recommendations not be included. Is there one that should be removed or none?

And then, the fourth question really focuses on that crosswalk analysis where we are asking for each specific recommendation is there any functional criteria that's listed under the first part where we look at alignment with the 2015 edition or the second part where we look at where we believe there's alignment with the proposed new or updated certification criteria. Is there anything here that should be removed as a correlated item to support the recommendation? In other words, you believe that this is not relevant to support the implementation of this priority in practice. That is the heart of Question 3 and Question 4 that lends itself to concise, bulleted responses. Questions 1 and 2 are more narrative. And we think that these issues in terms of how this relates to safety concerns impact really looking at gaps and barriers and what can really impact or support the feasibility of this in practice.

How the effective use of health IT can support the recommendation as it pertains to issues such as work flow, provider training, other safety and usability considerations. These types of topics and narratives we think we can capture in bulleted, narrative form organically through the discussions on each recommendation that begins with the focus on Questions 3 and 4.

So, this is the document of the pediatric technical worksheet. I wanted to just walk through how it was designed to help capture the work to date and enable stakeholders to provide meaningful comment pertaining to these recommendations in our rule. Let me stop there, again, for clarifying comments from the chair and co-chair or any of the task force members before I turn this over really to Chris to walk through each recommendation and then, to Al Taylor to just talk through, at a high level, the criteria. Our goal today is really to familiarize you with the recommendations and the worksheets.

And we envision that in future meetings we'll really have more time to focus on each one, get deep, and focus on these questions that correlate the charge.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you. I just want to emphasize that these four questions will be something that we will be touching back onto with every one of the proposed requirements. So, keep them in mind. Consider issues that would make it difficult for the application of them in pediatric care. Look for challenges to vendors. Look at any kind of unintended consequences that they might have that might actually be detrimental to pediatric care. And these recommendations have a long history behind them in pediatric EHR format and the reduced recommendations from 2015. And then, the final recommendations that were boiled down to 10. However, that doesn't mean that, even though we have been talking about them for years, it doesn't mean they're sacrosanct.

It doesn't mean that they cannot be modified or thrown out. So, keep that in mind as well. These are important things that this group will discuss and provide recommendations for.

Carolyn Petersen – Individual - Co-chair

The only thing I can add to that is that we should also be thinking about what we recommend with regard to access by patient and parents and caregivers. It is also a part of ONC's larger mission to ensure and further patient access. Obviously, we won't have very small children doing that. But, certainly, in some cases, their parents will need to do that. Adolescents will have an interest in accessing information. And it's important that we don't propose or recommend anything that might be a problem to make accessible via portals or APIs or through other means by which patients and parents might also want to look at their information.

Samantha Meklir – ONC - SME

Thank you. Are we now ready to walk through each specific recommendation? Dr. Lehmann, you can describe the functionality intent. And then, Al, you can walk through some of the crosswalk analysis.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Sounds like a plan.

Samantha Meklir – ONC - SME

Okay. My suggestion would be that we scroll through the technical worksheets in real time as

correlates to each recommendation that's being focused on. Thank you.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

All right. So, here we are at our first recommendation. Keep the four questions in mind. The title is a little awkward. User biometric specific norms for growth curves. But what it really means that in electronic health record use in pediatric care shall be able to include the ability to use pediatric specific norms for weight, height, length, head circumference, and BMI to calculate and display growth percentiles and plot them on one of the standard curves either from the CDC or the World Health Organization as appropriate. And as appropriate refers to a kind of thing that occurs at two years of age.

So, what this metric pretty much says is when you enter the height or the weight of your patient or the BMI, the system should be able to calculate based on the age of the patient, what percentile the child is on, and should be able to plot out a trend so you can see in a visualization how the child is doing in the form of growth and development. I'll turn it over, at this point, to Al.

Al Taylor – ONC - SME

Sure. So, the 2015 edition certification criteria that we believe addresses the concern about the use of growth curves, No. 1 is the common clinical data set, which is used as the core data set for the consolidated document architecture, the CCDA, which is the standard document format that EHRs have to certify to. Within that common clinical data set are some optional criteria, including the metrics that Chris just went over, including the BMI, head circumference, length, and weight for length, and head circumference for age. So, those are optional criteria. But there are implementation standards for use of those vital signs in the optional pediatric vital sign data within the common clinical data set. Demographics, obviously, there is a standard for male and female, which, obviously, inform the two different growth curves.

In order to make use of the data and make better decisions for the data, the standard surrounding clinical decision support can take these numbers and alert the provider to deviations from the norm in order for them to possibly make interventions. The application programming interface enables a variety of functionalities to either access data from other sources or to populate data from other sources into the EHR. And I believe those collectively really do address the concerns of the need for growth curve data using growth curve data appropriately in the EHR. The proposed new criteria include US core data for interoperability. And that you can think about this as an extension of the common clinical data set. And the vital sign data that we've mentioned for the CCDS are included in that as well. Can you scroll down some or next page, please?

And the same thing with the APIs, the update to the API standards is also in the proposed rule. So, we believe that those will also continue to address those needs. Sam, are we going to cover the supplemental requirements as well?

Samantha Meklir – ONC - SME

No, my recommendation is that we move on.

Al Taylor – ONC - SME

These are sort of additional criteria that were proposed as not the first line recommendations in the 10 criteria. These are related requirements that were proposed, but they're discussed here. So, I think we can move on to Recommendation 2.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Yeah. Sam, a point of clarification. The discussion of those will be on subsequent calls, correct?

Samantha Meklir – ONC - SME

Correct. I think that these will be integrated into the focus of the recommendations when you roll up your sleeves in terms of then, looking at the relevance of these for that overarching question.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Okay. Thank you.

Samantha Meklir – ONC - SME

We do preliminary crosswalk analysis for each of these as well, and we lay that out here. In the interest of time for today's call, I think focusing on the key top level recommendation.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Okay. That takes us then to Recommendation No. 2, compute weight based correct dosages. The recommendation includes that the EHR will compute the drug dosed based on the appropriate dose ranges using the patient's body weight or surface area and shall display the dosing weight, the weight based dosing strategy when it's applicable on the prescription. This is a safety feature. As you know, at about 45 kilograms, most children require weight based dosing or body surface space dosing. The ability to show your work by displaying what weight was used for calculation and what dosing strategy was used allows the pharmacist or somebody who is administering the dose downstream to actually be able to double check and verify that things were reached with an appropriate strategy and adds safety to the medication dosing of children.

Al Taylor – ONC - SME

With regard to weight based dosing, the 2015 certification criteria do address this, although the requirement for the standard, which is the NCPDP script standard for electronic prescribing, has within it the ability to transmit weight and height and other information within the structured prescription, the structured sig. That particular part of the NCPDP script standard was not adopted because of industry readiness in the 2015 rule. However, that capability within that same standard that was adopted in 2015 does exist. And as this standard and the subsequent standard that replaces it is sort of rolled out, the capabilities do exist. Obviously, it requires adoption in order to implement these standards.

But these standards will be able to address the requirements for weight based dosing, weight

and other metric based dosing for peds and other settings as well, including ICU and other areas as well. As before, the US core data for interoperability standard contains the weight and other metric data that can be used to populate E prescribing standards. And I believe that continues to support this requirement.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Are there any questions or comments to this one?

Susan Kressly – Kressly Pediatrics - Member

So, this is Sue. I just wanted to be mindful of timing. And I don't know what the goal is for when this work is to be done. But we're in a position for now, for example, for vendors who have not finished or completed 2015 certification where the, and I can't ever say the letters in the right way, the pharmaceutical script standard, there are a lot of third parties now making people go certify with the upgraded transmission of pharmaceutical information through the drug certification. And so, they're sort of like ONC is only prepared to test in the 2015 version with the old script. But people are moving to the new script.

So, we've just got to be really mindful about not having a disconnect about the timing of when we make recommendations and where the certification for E prescribing timeline fits in that.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Okay. Thank you. Shall we move into No. 3? So, No. 3 is a recommendation that focuses on the ability to access family history. And there is an important subset, the data on guardians and caregivers. So, the EHR shall be able to provide the ability to record information about all guardians and caregivers, which, in this day and age, is becoming increasingly complex. Biological parents, foster parents, adoptive parents, guardians, surrogates, custodians, etc., siblings and case workers with contact information for each. The role, as well as the contact information, will be critical in order to provide the care coordination to do things like child abuse reporting, management of complex patients, and is vital to the work of pediatricians.

Al Taylor – ONC - SME

So, with the 2015 certification, the criteria that addressed this, at least partially, are the care plan, which is able to communicate the requirements for care between the providers who are jointly taking care of the patient. The care plan contains a good deal of information about the individual patient, the pediatric patient, which can be used to coordinate the care. The transitions of care in the same respect. The transition in care document is able to communicate between providers using standardized health data. The API interface, the application programming interface, is also used as a way to facilitate exchange of information between providers. And demographics has the ability to some extent but probably not as extensive as required for the multiple layers of both caregivers and custodians for the children.

But it does have some abilities to thwart that to identify parts of both the care team and the custodial arrangements for the children. Next page, please. And the same thing for the proposed rule. The core data for interoperability has the demographics information as well as

a number of different data elements regarding the kids, including the vital signs required for that, data segmentation for privacy in order to protect the information from disclosure for certain family members, as well as for certain caregivers. The current version in 2015 protects the disclosure of these care plans and transition of care documents from unauthorized disclosure. And the proposed rule for data segmentation allows for segmenting of more discreet data that can be designated for some of the information that should and can be disclosed and others should be protected from disclosure and redisclosure.

And API, again, is an extension of the current API rule as well. Back to you, Chris.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you. And the transition here to the next one, you already made it, Al. We're talking the next recommendation segment as access to information, which you touched upon. The requirement includes the ability to segment healthcare data in order to keep information about minor concern services private. In the past, we always thought about adolescents and the services related to STIs or pregnancy. But, again, with the recent discussions in congress, we are also thinking about vaccination data. We just saw this young man who was vaccinated when he turned 18 against his parental wishes. So, the ability to keep services sequestered from those that shouldn't access them is a requirement that's recommended for the care of children. Al?

Al Taylor – ONC - SME

So, we did cover this. The 2015 certification is limited in the ability to only have whole documents. Some of the information within the CDA document is appropriate for disclosure. But if the entire document is protected from disclosure and redisclosure, then, there are some limitations to document level marking or security indications. With the proposed rule, down to the data element level is proposed to enable the marking and segregation of discreet data. So, some of the information about the child's care may be able to be more freely shared. But some of the more sensitive data like Chris mentioned with STIs and pregnancy, those sorts of things can be marked for segmentation and nondisclosure. So, what I just mentioned is on the next page as well with the proposed rule.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you, Al. And just as a reminder to this group, the devil is in the details here. The most likely source of disclosure of information that actually should be prevented is in the billing information. So, that's an important issue to keep in mind when we talk about this later. All right. I think we're on to No. 5. The next item is the Recommendation No. 5, synchronizing immunization history with registry it's pretty straightforward. The system shall support, update, and reconcile a child's immunization record with information received from immunization information systems or other health information exchanges. It allows the pediatrician to identify immunizations that may have been given elsewhere to reduce duplicate immunizations, identify and use immunization forecasting to predict immunizations that are needed and schedule appropriate healthcare maintenance around immunization. Al?

Al Taylor – ONC - SME

So, this particular criteria is probably the most specifically accomplished in the 2015

certification criteria, which does specifically include immunization history from the immunization registry in the state, as well as you get not only the information exchanged with immunization registry is not only history but also forecasting for required or recommended vaccinations. And this is provided directly back to the provider on request. So, this actually already meets the requirement. There are some variabilities in the adoption of this standard and the variabilities and the availability of interstate immunization history, which is obviously pertinent in some settings. But this functionality already exists and is fairly widely implemented in EHRs and in most states. View, download, and transmit is the ability of individual patients or their representatives to download that information.

And the information that has been incorporated into the record is the information that they're going to be able to get with view, download, and transmit. So, that also addresses that requirement. Although, view, download, and transmit is not specific to immunizations. But it is part of the information that can be obtained with patient access to the record.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you. Then, moving on to Recommendation No. 6, flipping back and forth here between my copy and online. Anyway, Recommendation No. 6 is age and weight specific dose range checking. My recommendation later when we are discussing this is that we move this closer to the discussion about weight based dosing and that we have I think it was Recommendation No. 2. Here, the recommendation is that the system shall provide medication dosing decision support that detects drug doses that fall outside the maximum and minimum range based on the patient's age, weight, and maximum recommended adult dose, of course, if they're known, and the maximum recommended pediatric dose for medications. You'll note that there's an emphasis on maximum. When we talk about this, we'll talk about the value of minimum dose based recommendation or the lack thereof.

But this recommendation, essentially, will help people to stay within an appropriate range of direct dosing for pediatrics. Al?

Al Taylor – ONC - SME

Thanks. The issue about drug dose checking, both min and max, whether it's based on age or weight specific, is a functionality that is not contained within the E prescribing standard, both either the standard or the implementation of the standard. Although, as we've said before, the ability to transmit age and weight through demographics and pediatric vital signs is there. The NCPDP implementation guide for the script standard acknowledges the fact that there is not embedded within that standard the ability to transmit dose range checking and dose range recommendations. They point instead to third party vendors to provide that whether it's manufacturer provided or pharmacy services providing the information about dose range recommendations.

So, this is not a functionality that currently exists within the prescribing standard, although some of the supplemental information that you get for the vital signs is available. The decision support standard has the ability to access external dose range recommendations and provide information to the provider. But it is not integral to the E prescribing standard or the prescribing functionality within the current EHR or in the proposed standards with the

proposed rule. The USCDI, again, provides some supplemental information that can inform this. But the functionality does not exist in the certification at this time.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you, Al. I think this will be a hot topic for discussion. Let's move on to No. 7, which is transferrable access authority. This recommendation reflects the reality that children don't stay children for the rest of their lives. The system shall be able to provide a mechanism to enable access control that allows transferrable access of authority. For example, if a guardian changes or the child becomes an emancipated minor or reaches adult age, I think this is a pretty straightforward requirement and will enable the transition of care from pediatrics to other specialties.

Al Taylor – ONC - SME

So, the issue with transferrable access is kind of the key phrase here. The ability to access information is accomplished by the view, download, and transmit functionality in a standard within the current certification criteria. It is the transferrable access that is dependent on the administration of the authorized representative, which is some specific language within the VDT standard. And it is how that authorization is granted and changed within each implementation that is really key. That authorized representation is going to be highly dependent on local state laws around security and privacy. And so, that's not really realistic to say that an EHR standard can address each local authority requirement. But within the administration of the authority to access via VDT believe that that's taken care of, but it's taken care of outside of the certification requirements of EHRs.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you. Then, moving on to Recommendation No. 8, this was a little bit different than other recommendations that we have seen so far. It's a little bit outside of the standard recommendation box. The title is Associate Mothers, Demographics with Newborn. And the recommendation states that the system shall provide the ability to associate identifying parents or guardians demographic information to the relationship to the child, address, phone number, and email address for each individual child. Really, I think this aligns a little bit with the prior requirement about being able to document all guardians, stakeholders, case managers, etc. But I'm just going to stop here and turn it over to Al.

Al Taylor – ONC - SME

Thanks. There are a number of electronic health records that have the ability to import maternal data into newborn records. There is not currently a standard for that, but it is something that is practiced. It is something that is practiced in EHRs. The ability to put some of the information from the maternal data, which obviously is required, is really critical information for both labor and delivering as well as newborn care. Some of that information can be contained within the care plan and transition to care documents. It can be contained within family health history, including some of the social, psychological, and behavioral data that can be available with regard to the maternal social determinants. Health, obviously, will have an impact on the newborn determinants of health.

And so, some of that information can be provided under the standards. However, there's not

a well developed standard way to import data from a specific relative; namely the mother, or a specific relative; namely any of the parents or siblings transmit that information into the next record whether it's inpatient to outpatient, newborn to pediatric, or from maternal to newborn. But some of this information can be transmitted using these methods under the current and the proposed certification criteria.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you, Al. And thank you for going into the maternal data for the newborn. I think this is going to be a recommendation that will also play an important role when we discuss opioid use disorder and neonatal abstinence syndrome because the maternal information about the morphine equivalent doses per day, for example, may play an important role for the long term care of the child and the duration of hospitalization, etc. With that said, we're moving on to Recommendation No. 9. Here we go. The recommendation is titled To Track Incomplete Preventative Care Opportunities. I have to admit that this one is very near and dear to my heart. One of the things that pediatricians and family practitioners and those who take care of children do and do well is to provide preventative measures and to screen children based on recommendations that ultimately lead to long term improved health and outcomes.

And we've specifically referred to, in this recommendation, to the Bright Futures from the American Academy of Pediatrics that has our recommendation for well child visits and interventions that should be done in wellness visits that can include things like hemoglobin at age 1 to test for anemia, developmental screenings, etc. So, this measure will suggest that the system should provide a recommendation, a list for children who have missed these recommended health supervision visits or interventions and help with decision support to providers. Al?

Al Taylor – ONC - SME

Thank you. The good news here is the capabilities and the electronic health record are capable, and they have always been capable to detect, both before the fact and after the fact, a number of different clinical criteria, including the presence or absence of immunizations, presence or absence of vital signs for blood tests or any number of different things. And the EHRs do this through either clinical decision support, which can provide information based on existing data to the provider in order to provide care at the point of care and at the time of care. The clinical quality measures are anybody who reports to Medicaid or Medicare understand is typically after the fact. But it can provide a measure of how well a provider is complying with those recommendations.

The key problem right now is most of the Bright Futures recommendations and other healthcare maintenance recommendations have not been codified into an electronic clinical quality measurement or electronic clinical decision support, although the technology exists. And with some investment both by the government, Medicaid, or Medicare or with other stakeholders like the AAP that kind of technology or that kind of measurement and decision support can be implemented using current technology. It's just that those rules have not been packaged together in a way that could be of assistance for providers. Chris? You might still be muted. It might be muted again.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

My apologies. I was talking. Thank you for reminding me. Yeah. I think this was a great summary, Al, about some of the challenges associated with Bright Futures. We have some data related to that about decidability and actionability. So, those are good comments. And I think we'll have a healthy discussion around this. And I think, as you pointed out, it's a need for some of the stakeholders to go back and work on the recommendations in a way that it becomes easier to be implementable.

Al Taylor – ONC - SME

And Chris, I just wanted to say, and I didn't point this out specifically, but some of the Bright Futures recommendations have been implemented and are currently part of program clinical quality measurements for providers. There's just not that many at this time.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Yeah. And there's a fascinating article by Steve Downs and his group about the decidability and actionability of Bright Futures. And I think there is potential to improve. Moving on to No. 10. The title is Flag Specific Healthcare needs. The recommendation is that we should have the ability for providers to flag or unflag individuals with specific healthcare needs, complex conditions, who may benefit from care management, decision support, care planning. And this flagging should support reporting such as quality measures. So, the use case here is individuals with diabetes or asthma that require special attention or special care management or care planning.

And it is something that is not necessarily pediatric specific but might be very useful for adult patients as well. Al?

Al Taylor – ONC - SME

Right. And, again, those specific examples that you provided are good examples because they point to existing both quality measurement and decision support around the care of patients with specific diagnoses. There are quality measurements in place in implementation around the care of asthmatics, although it does not necessarily include the presence or absence of an asthma action plan. The care of diabetes includes some of the specific requirements for long term care for diabetics. So, these are implemented in clinical decision support and, in particular, the clinical quality measurements.

And so, identifying what those rules are and taking the next step to codifying them into these decision support and quality measure artifacts using the current technology, using the 2015 certification criteria are very much like the Bright Futures recommendations. There is work to be done but it's work to be done with the currently implemented technology.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you, Al. So, I think that's the list of recommendations. And I'm going to turn it over back to Sam.

Samantha Meklir – ONC - SME

Thank you so very much. So, I want to thank Dr. Lehman and Dr. Taylor for walking us through the recommendations and the granular crosswalk analysis. We hope that this was really helpful as you prepare for the subsequent discussions where we roll up our sleeves and really revisit these in a deeper, more focused manner. I'd like to turn now to let's go to the next slide. Okay. So, as we mentioned on the top of the call, part of the charge involves a request for information that we have as part of the care continuum section of the notice of proposed rulemaking. Let's go to the next slide. On this slide, what we've identified is that Section 6 of the rule that addresses the health IT for the care continuum obviously has a significant part with the health IT for the pediatric setting. That's found in Section 6A. Section 6B is the request for information on health IT and opioid use disorder prevention and treatment or what we refer to as an RFI. On this slide, we have a general sense.

This really correlates to when you look at the preamble of the RFI, what we indicate is that we have identified several 2015 edition certification criteria that are available now for certification in the program that we think could support some of the clinical priorities and that could support some of the functions related to opioid use disorder prevention and treatment. So, similar to what we just walked through with pediatrics, we lay out what we believe the existing or proposed or new criteria are that we think are relevant to supporting OUD prevention or treatment. Some of these include, for example, transitions of care or some of the patient health information capture. And we go through and we list out these criteria. For purposes of what we're asking the committee here to do, we're not asking for a granular crosswalk analysis of defining or identifying what those clinical priorities are or how they would crosswalk to specific criteria.

Rather, what we're asking is your general sense of how our program holistically as can support OUD related prevention and treatment. In other words, the value and relevance for the approach for informing OUD prevention and treatment. So, we welcome input on that. Again, we're not asking for the granular analysis. I hope that is clear. But, generally, is it valuable, is it important? What is your general sense of what we laid out in applying this three part approach to OUD as part of this RFI? So, that is more of a holistic input for the general sense question. If you go to the next slide, here is where we have more targeted topics of focus for the committee to focus on. As Chris referred earlier, a large part of this involves the neonatal abstinence syndrome or NAS, as we indicated earlier, the data segmentation for privacy. And then, there is a part of the RFI that focuses on electronic prescribing and prescription drug monitoring programs.

So, these three topics, NAS and DS for P, and we break down some of the areas of focus for the committee to really hone in on in addressing these aspects that are contained in the request for information. Let me just point to the data segmentation for privacy, which is included. That proposal is in what Al walked through under new or proposed. That is in Section 4 of Rule No. 7, I believe. And that is that the B12 and B13 as relate to the CCDA, and then, as it relates to Fyre that is the G11. So, what we're asking for here is really how that proposal and the other section of the rule your input as it relates to OUD prevention and treatment. So, the applicability of that proposal through that OUD lens. And then, obviously, as part of the analysis and input on the pediatric recommendations as it relates to the pediatric setting and use case as well.

So, those are three key topics of focus that we are excited to have you provide some insights and information to us on. Let me pause there for clarifying. I want to reintroduce Zoe Barber, my colleague at ONC, who is also supporting our work here. And let me just see if there are any clarifying comments here either by the chair or co-chair or from any ONC team members as pertains to the OUD content.

Carolyn Petersen – Individual - Co-chair

I don't have any questions. Thank you.

Susan Kressly – Kressly Pediatrics - Member

So, I have a general question. This is Sue. Clearly, some of this is not my specific expertise, especially some of the PDMP stuff. But I have access to people who it is their expertise. As part of this task force, are we allowed to cast a wider net so we can be better informed and bring a broader view to the discussion?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

This is Lauren from ONC. Yes, absolutely. If there is a specific subject matter expertise that would bring additional insight to the group, I'm happy to invite them for a future call.

Susan Kressly – Kressly Pediatrics - Member

Great. I'll follow up offline.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Excellent question, Sue. Thank you.

Samantha Meklir – ONC - SME

Any other clarifying questions or comments? Okay. Thank you. I think next on the agenda, and we are on time, is a review of the work plan. And then, we would open it up for public comment. So, let's transition now to the work plan slide. So, Carolyn and Chris, did you want to walk through this? Or would you prefer the ONC team to go through some of the timing here and have Lauren and Stephanie walk through this?

Carolyn Petersen – Individual - Co-chair

I can talk through that. Thanks. So, this is kind of our general timeline and the guiding document that we'll use as we work through this large, multipart charge. As you can see, today, we're having our kickoff. And we've gone through all of the work that we will be doing over the next few weeks. In general, our meetings are scheduled for Friday mornings early. We thought that was a good time for everybody to be able to get on the phone. I think it's also helpful for Chris and I and the ONC staff in that if there are things that we need to accomplish, we then have a weekend handy to get a start on that so that we can be prepared for the following task force meeting. On Friday, we will start getting into the discuss and I think looking at the 10 recommendations first considering how we need to update or revise or perhaps delete those if that's appropriate.

We anticipate that will continue for a couple of weeks. And then, at the March 19 and 20 meeting here in just a couple of weeks, Chris and I will present a review of what we have accomplished and the work group has accomplished so far to the full HITCC. We will continue on with another three meetings to continue refining these recommendations and providing new ones for the additional topic areas that we have in our charge. And then, there will be another update to the full HITCC committee on April 10. You're welcome to dial into those meetings if you'd like. The information about calling in and agenda will be made public in advance so you can do that in a time efficient fashion. Oh, another task force meeting on April 19 where we'll continue our work. And then, towards the end of April, we'll be presenting the final recommendations to the HITCC, if we haven't finalized those sooner.

In the last week of April and into May, ONC will be preparing the final transmittal letter from the full HITCC. And then, those recommendations from HITCC are submitted to NCNregulations.gov on or before May 3. So, things will be moving fairly quickly. But I think for us in that we're able to have weekly meetings, it kind of helps the structure around that. And, hopefully, we'll create an efficient and easy to manage way for all of you to give us input and help keep the task force moving. Do you have any thoughts to share, Chris, about the work plan or the timeline?

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

No, you covered it all, Carolyn.

Carolyn Petersen – Individual - Co-chair

Then, I think this is a good time to take any questions from the task force members or from ONC or if there is anything we need to clarify.

Chip Hart – PCC - Member

No questions from me. This is Chip.

Susan Kressly – Kressly Pediatrics - Member

I'm good.

Carolyn Petersen – Individual - Co-chair

Okay. Well, it sounds like we are set to go as far as getting started with our work plan on a Friday. So, I will hand it back to Lauren for the public comment period.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Thanks, Carolyn. At this time, operator, can you please open the lines for public comment?

Operator

Certainly, if you'd like to make a public comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue, and you may press star 2 if

you'd like to remove your comment from the cue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

And I know we're just a few minutes ahead of schedule. So, Sam or Stephanie or Zoe, if there's anything else that you want to cover in the last 10 or 12 minutes or so, let me know. Otherwise, we will adjourn. And then, for the ONC staff and the chairs, if we end early, we'll just immediately jump to our debrief call. Operator, do we have any comments in the cue at this time?

Operator

We have none at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

And were there any other task force members that joined later that I didn't catch at the role call? Okay. I just want to make sure that we didn't miss Raj. Okay. With that, I will turn it back to our co-chairs for any closing remarks, unless Sam or Stephanie, if you have anything else.

Samantha Meklir – ONC - SME

I would just offer to the task force members all of the attachments for this kickoff meeting. Several of them contain useful background information and some background reading that our chair and co-chair collated as well. So, there is a lot of content by way of background that we aim to provide to support your endeavors here.

Chip Hart – PCC - Member

Having been in a lot of these meetings, I will tell you that your background material is much better than what we usually get. So, thank you.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you.

Carolyn Petersen – Individual - Co-chair

Well, I think with that, I will just conclude my part of the meeting by thanking everyone for coming this morning and sitting patiently as we go through our charges. I'm really excited about diving into the work on Friday and am happy to be a resource or a source of assistance as you work through the very specific details of these recommendations. Thanks for joining, and I'm looking forward to working with you.

Chip Hart – PCC - Member

Thank you.

Chris Lehmann – Vanderbilt University Medical Center - Co-Chair

Thank you, everybody.

Susan Kressly – Kressly Pediatrics - Member
Thank you for the opportunity. Bye.