

# Meeting Notes

## HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC)

September 9, 2020, 9:30 a.m. – 12:30 p.m. ET

VIRTUAL



## EXECUTIVE SUMMARY

**Donald Rucker** welcomed members back from the HITAC's summer break and gave an overview of some of ONC's COVID-19 response efforts and other recent work completed. He provided an overview of the meeting agenda and congratulated **Cynthia Fisher** and **Arien Malec** on their reappointments to the HITAC. **Carolyn Petersen** and **Robert Wah** reviewed the meeting agenda, and the minutes from the June 17, 2020, meeting of the HITAC were approved by voice vote. **Laura A. Conn** and **Adi Gundlapalli**, from the Centers for Disease Control and Prevention (CDC), presented on the topic of using electronic case reporting (eCR) to accelerate implementation for COVID-19 reporting. HITAC members submitted feedback, and a discussion was held. **Carolyn Petersen** and **Aaron Miri**, co-chairs of the Annual Report Workgroup (ARWG), presented an update on the ARWG's recent work, including the crosswalk of topics for inclusion in the Fiscal Year 2020 (FY20) Annual Report. **Sheryl Turney** and **Alix Goss**, co-chairs of the Intersection of Clinical and Administrative Data Task Force (ICAD TF), presented an update on the TF's recent work, including guiding principles and draft recommendations developed as part of the ICAD TF's work on a draft report for submission to the HITAC. HITAC members submitted feedback and questions, and a discussion was held. There were four public comments submitted by phone, and there was a robust discussion and comments in the public meeting chat via Adobe.

## AGENDA

09:30 a.m.	Call to Order/Roll Call
09:35 a.m.	Welcome Remarks
09:40 a.m.	Review of Agenda and Approval of June 17, 2020 Meeting Minutes
09:45 a.m.	Centers for Disease Control and Prevention Presentation
10:15 a.m.	HITAC Annual Report Workgroup Update
10:45 a.m.	Intersection of Clinical Administrative Data Task Force Draft Recommendations
12:00 p.m.	Public Comment
12:15 p.m.	Wrap Up and Final Remarks
12:30 p.m.	Adjourn

## CALL TO ORDER/ ROLL CALL

**Lauren Richie**, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the September 9, 2020, meeting to order at 9:30 a.m.

## ROLL CALL

**Carolyn Petersen, Individual, Co-Chair**

**Robert Wah, Individual, Co-Chair**

Michael Adcock, Magnolia Health

Christina Caraballo, Audacious Inquiry

Tina Esposito, Advocate Aurora Health

Cynthia A. Fisher, PatientRightsAdvocate.org

Valerie Grey, New York eHealth Collaborative

Anil Jain, IBM Watson Health

Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)

John Kansky, Indiana Health Information Exchange

Ken Kawamoto, University of Utah Health

Steven Lane, Sutter Health

Leslie Lenert, Medical University of South Carolina

Arien Malec, Change Healthcare

Clem McDonald, National Library of Medicine

Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin

Brett Oliver, Baptist Health

Terrence O'Malley, Massachusetts General Hospital





James Pantelas, Individual  
Raj Ratwani, MedStar Health  
Abby Sears, OCHIN  
Alexis Snyder, Individual  
Sasha TerMaat, Epic  
Andrew Truscott, Accenture  
Sheryl Turney, Anthem, Inc.  
Denise Webb, Individual

## MEMBERS NOT IN ATTENDANCE

Amy Abernethy, Food and Drug Administration  
Steve Ready, Norton Healthcare

## FEDERAL REPRESENTATIVES

James Ellzy, Defense Health Agency, Department of Defense  
Adi V. Gundlapalli, Centers for Disease Control and Prevention  
Jonathan Nebeker, Department of Veterans Health Affairs  
Michelle Schreiber, Centers for Medicare and Medicaid Services  
Ram Sriram, National Institute of Standards and Technology

## ONC STAFF

Donald Rucker, National Coordinator for Health Information Technology  
Steve Posnack, Deputy National Coordinator for Health Information Technology  
Elise Anthony, Executive Director, Office of Policy  
Andrew Gettinger, Chief Clinical Officer  
Avinash Shanbhag, Acting Executive Director, Office of Technology  
Lauren Richie, Branch Chief, Coordination, Designated Federal Officer

## WELCOME REMARKS

**Donald Rucker** welcomed members back from the HITAC's summer break. He acknowledged that COVID-19-related activities were still front and center in the U.S. Department of Health and Human Services' (HHS) and the Office of the National Coordinator for Health Information Technology's (ONC) work and gave an overview of some of their other efforts, which included holding the all-virtual 2020 Tech Forum and funding activities with HL7 and the STAR Health Information Exchange Program, which will advance capabilities of health information exchanges (HIEs) in order to get high-quality longitudinal data for COVID-19 relief efforts. He provided an overview of agenda items for the meeting and then discussed some HITAC member updates, which included congratulating **Cynthia Fisher** and **Arien Malec** on their recent reappointments to the HITAC. Also, he noted that the HITAC co-chairs, **Carolyn Petersen** and **Robert Wah**, would be stepping down at the end of the year following the completion of their respective three-year terms. Any HITAC members interested in serving as one of the co-chairs were encouraged to contact **Lauren Richie** by September 16, 2020.

## REVIEW OF AGENDA AND APPROVAL OF MEETING MINUTES

**Carolyn Petersen**, HITAC co-chair, welcomed all the participants and thanked them for attending the virtual meeting. She thanked the individuals who serve on the Intersection of Clinical and Administrative Data Task Force (ICAD TF) and the Annual Report Workgroup (ARWG) for the large amount of work they completed over the summer.

**Robert Wah**, HITAC co-chair, welcomed the members back from the summer break and thanked those who contributed to work completed over the summer. He briefly described his experience testifying before the House Budget Committee on government IT procurement processes and noted his appreciation for **Dr. Donald Rucker's** assistance in preparing for the testimony. Then, he reviewed the agenda and listed the





presentations that would be held at the meeting.

**Robert** invited members to examine the minutes from the June 17, 2020, meeting of the HITAC. There were no comments or corrections submitted, so he called for a vote. The HITAC approved the June 17, 2020, meeting minutes by voice vote. No members opposed, and no members abstained.

## CENTERS FOR DISEASE CONTROL AND PREVENTION PRESENTATION

### Introduction

**Laura A. Conn**, MPH, eCR Lead, Health Scientist, CSELS, and **Adi Gundlapalli**, MD, PhD, MS, Chief Public Health Informatics Officer, CSELS, from the Centers for Disease Control and Prevention (CDC) presented on the topic of using electronic case reporting (eCR) to accelerate implementation for COVID-19 reporting.

**Laura** noted that **Adi** was in attendance on the meeting chat and explained that she would present on behalf of the team. She thanked the HITAC and ONC for the opportunity to provide an update on the CDC's progress and recent activities. She recognized the importance of the CDC's partnerships with the Association of Public Health Labs, the Council of State and Territorial Epidemiologists, the CDC Foundation, and the state and public health agencies, all of which helped to operate the electronic case reporting activity. Also, she thanked the electronic health record vendors and healthcare organizations for their engagement with the CDC's implementation.

### eCR Now

**Laura** began by describing electronic case reporting (eCR), noting that it is the automated generation and transmission of case reports from the electronic health record (EHR) to public health agencies for review and action. She stated that this automation takes advantage of data that exists in EHRs and happens behind the scenes, and it does not interrupt care delivery. She provided an overview of how the eCR Now Initiative has been used to identify and execute a strategic path to support acceleration of rapid implementation and remove barriers to conducting eCR for COVID-19 relief efforts.

**Laura** explained that eCR provides clinical data on patients to state and local public health agencies, and it is a critical tool for COVID-19 relief efforts and other reporting needs to state and local public health agencies. Paired together with the electronic lab reports, eCR begins to give public health a fuller picture of the data needed to take action in the case of a public health crisis. She explained that critical clinical data for outbreak management includes:

- Patient identity and contact information
- Co-morbidities
- Race and ethnicity
- Occupation
- Pregnancy status
- Travel history
- Other clinical data – medications, immunizations

### eCR Now Elements

**Laura** explained that she first introduced the eCR Now elements at the HITAC's April 2020 meeting, and a slide in the presentation depicted the infrastructure of eCR. **Laura** provided the following updates on each of the elements:

- Element 1: The key features of this element include rapid cohort-based COVID-19 eCR implementation for provider sites that have eCR enabled electronic health records.





- This is a standard ask for patient data from all jurisdictions implemented in as little as 3-5 days.
- Implementers added COVID-19 in the eCR early in the process in April.
- Implementers and facilities reporting were shared in the presentation slides.
- eCR statistics as of September 4, 2020:
  - All 50 states, DC, and eight large local jurisdictions have published a rule for COVID-19 and can receive electronic initial case reports from AIMS.
  - 57 of 59 jurisdictions have received at least one COVID-19 report from eCR.
  - 4,800+ facilities have implemented eCR for COVID-19,
  - 1.65 million+ reportable COVID-19 reports have been sent to 57 public health agencies.
- Element 2: The eCR Now Fast Healthcare Interoperability Resources (FHIR) App is available for other EHRs to use to do electronic case reporting for EHRs that do not otherwise have eCR capabilities.
  - eCR works with the FHIR DSTU2 or R4 APIs and is being implemented now in major commercial EHRs, and it can also be implemented by health systems or third parties.
- Element 3: A nationwide eCR trust framework has been built for eHealth Exchange, Carequality, CommonWell members, and those who connect to them. This means that that there are:
  - No additional legal agreements needed,
  - An APHL participation agreement for those not connected to any network,
  - No additional costs for the use of the eCR shared services, and
  - They have not seen COVID-19 charges from EHR vendors.

### eCR Now Call to Action

**Laura Conn** described the eCR Now call to action for healthcare organizations and providers, which included:

- Contact the CDC for a kick-off call: [ecr@cdc.gov](mailto:ecr@cdc.gov)
- Assemble your implementation team
- Begin implementation in a cohort
- Use the eCR Now FHIR app if your EHR does not have eCR capability
- Work with the CDC and others to turn off manual reporting

For EHR vendors, **Laura** noted that, until eCR is in regulation, the CDC is working on:

- Accelerating eCR implementation, including:
  - CDA approach
  - eCR Now FHIR app
- Supporting rapid rollout in partnership with the eCR Team

The presenters provided their contact information, thanked the entire eCR Team of staff and contractors, and recognized **Steven Lane**, a member of the HITAC, for his contributions.

**Robert Wah** thanked **Laura Conn** for the information and asked **Steven Lane** and any other HITAC members to provide feedback.

Discussion:





- **Steven Lane** thanked **Robert Wah, Laura Conn, Adi Gundlapalli**, and the entire rapid implementation and eCR advancement team for the work that has been completed over the past six months and submitted several comments:
  - There are advancements that have been made since the start of the COVID-19 pandemic and noted that there has been a need for increased engagement.
  - Various EHR vendors have or have not engaged with the process. Some providers have had trouble prioritizing or reviewing the process, while others were able to implement it in days.
  - There is a FHIR app for eCR available now.
  - For EHR vendors who have engaged, implementation has been remarkable and often cost-free (due to the pandemic).
  - The eCR HL7 standard is being reviewed to determine if additional data elements are needed, so comments on that subject should be directed to **Laura Conn** and the CDC.
  - It is clear that there is a broad need for the exchange of data between providers and public health, and eCR, among others, has been a piece of that process.
  - Solutions have been put together, leveraging standards-based interoperability to support data beyond patient-specific eCR.
  - Public health now has the ability to pull data from provider organizations using the quality care framework, and there has been a great deal of related innovation to support public health interoperability.
  - Keeping up with requests for data from public health agencies has been challenging, highlighting the need for technologies like eCR to exchange data for use cases.
- **John Kansky** noted that there has been a suggestion to engage HIEs one at a time or as a group and explained that the hybrid approach could be complicated. He described his experiences working with the Indiana State Department of Health to respond to eCR transactions on behalf of healthcare providers as a way to ensure coverage quickly and suggested that other states could benefit from a similar approach, even though it raises the question of interoperability through intermediaries versus directly through point-to-point sources.
  - **Laura Conn** thanked him for his comment and noted that the CDC already has a number of eCR flows coming through HIEs, including in Wisconsin and Kentucky, and noted that this can provide a big advantage.
- **Aaron Miri** thanked the CDC team and recognized **Steven Lane** for the work he has done behind the scenes. He discussed his experiences working with vendors in the community to implement eCR at UT-Austin and highlighted the importance of public health data in the process while noting that there are disparities in the data and that many do not understand all of the public health elements. He described how the UT-Austin campus is reopening and noted that his team, which has been doing all of the contact tracing, has had to lead the charge behind explaining and using eCR. He suggested that a collective effort around public health, including potential regulatory/legal work, is needed to enforce and mandate this process. He asked **Laura Conn** and the CDC team if CommonWell and Carequality are on the near-term horizon, as they would be useful in getting past challenges he has experienced with vendors.
  - **Laura** noted that the trust network for those is already in place and usable and asked **Steven Lane** to comment.
  - **Steven** asked **Aaron** to let him know of any issues, as they have been responsive when putting the trust framework into place. Carequality is open to making changes as needed.
  - **Aaron** responded that he would be in touch.





- **Raj Ratwani** inquired about any potential barriers and challenges that would prevent the wider adoption of eCR. Also, he asked what barriers organizations faced that have considered eCR but did not fully engage in the process and how the HITAC could support overcoming these barriers.
  - **Laura Conn** responded that when the CDC has been able to engage in a dialogue with an organization, they have generally moved forward with implementation. Organizations that did not implement have had resource and capability constraints, even though they noted their interest.
  - **Steven Lane** explained that capability, prioritization, and aligning incentives have been challenges and discussed the example of California's state public health department's struggles to keep up with technology and COVID-19-related challenges. He noted that other states have analyzed data from the eCR and have decided that it met the case reporting requirements, allowing for the manual process to be stopped. He suggested that regulation would push some states forward and more standardization across public health agencies in public health reporting and bidirectional data exchange. eCR, along with the established EMR and syndromic surveillance feeds, can help. Even in the absence of fees, adoption has been a challenge.
  - **Raj** noted that the comments were great and highlighted three challenges:
    - Prioritization
    - Incentives
      - The first two challenges are organizationally specific and might be more difficult for the HITAC and ONC to address, though it can be done.
    - Capabilities: **Raj** noted that this challenge is troublesome because the larger healthcare facilities and systems that can leverage eCR and integrate other technologies within the EHR will do it, and those that do not have the capability will not use new technologies. This widens the discrepancy between how care providers can serve patients across the ecosystem, and he asked HITAC members to comment on this potential struggle.
- **Denise Webb** thanked **Laura Conn** and her team for their work on eCR and noted that, in her previous experience working in public health in Wisconsin, she appreciated the importance of public health reporting and data. She discussed Wisconsin's leveraging of HIEs to serve the goals and vision to reduce the number of point-to-point interfaces and burden on the system and providers. She explained that she recently joined a specialty clinic in Indiana as an interim CIO, noting that these smaller clinics face resource, vendor cooperation, and other pandemic-related challenges, and asked if there was a published list of eCR participating vendors.
  - **Laura Conn** noted that she would be happy to speak with **Denise**, individually, about the list of vendors and their capabilities. The CDC has not publicly published such a list at this time, and a number of vendors have plans to prioritize and accelerate their implementation capabilities.
  - **Denise** thanked **Laura** for the response, noting that they would speak offline, as the cooperation of the vendor community is still necessary to go through an HIE.
- **Arien Malec** thanked **Laura Conn** and the CDC team for the presentation and submitted several comments, including:
  - He shared his experiences looking at eCR in the context of the Duke-Margolis report on interoperability for public health and COVID-19, noting that eCR was outside the framework at the time the report was released.
  - Then, he highlighted the importance of case reporting and electronic lab





reporting as measures that aid contract tracing, prevent community spread, and support the return to work and economic normalcy until vaccination is widespread.

- He discussed prioritization issues between EHRs and health systems and suggested that ONC, along with the CDC and the White House Task Force on Coronavirus, publish a roadmap to help organizations prioritize tasks.
- He noted that regulatory timelines related to the certification process are long and cumbersome, so it would be helpful to publish accelerated guides/roadmaps for certification.
- He suggested that Congress and the White House could grant capabilities to public health authorities and provider organizations, along with a roadmap, to address resource limitations.
- Prioritizing a list of suggestions will drive steady progress to get through the COVID-19 crisis.
- **Les Lenert** thanked and congratulated the presenters and submitted several questions:
  - What has the CDC learned about data quality over the course of the pandemic, and where are the gaps?
  - Has eCR had an impact on the availability of timely data at the local and national levels?
  - What opportunities are gained for improving the efficiency for healthcare providers when eCR is combined with using HSN/other federal pools to report hospital capacity, assuming that this allows for the assessment of the number and severity of cases and their potential impact on the healthcare system?
  - **Laura Conn** thanked **Les** for his comments and noted that the CDC is doing an initial check on data quality as they are implementing and has an ongoing dialogue with the production side and public health agencies. Also, an evaluation plan is in place, and work has begun on data sharing agreements with public health agencies to share data with an evaluation team supported by the CDC Foundation. She discussed the effectiveness of the processes used in New York City and Utah, where case reports and contact information were used to begin contact tracing before lab reports were submitted. Then, she discussed how eCR has been working with the National Healthcare Safety Network to identify cases that need to be reported to other data streams. She asked anyone who was interested in participating in discussions on how to take advantage of data sources to contact her.
- **Aaron Miri** responded to other HITAC members' comments:
  - In response to **Denise Webb's** comments, he suggested that her system look into EHR vendors that have FHIR capability and referenced a document from one of the Federal Advisory Committees (FACs) that laid out a list of these vendors. He explained that some vendors will not be able to prioritize implementing a FHIR app until mid-2021 or later.
  - In response to **Raj Ratwani's** question related to patient safety, he highlighted the timeliness of detection and response by discussing the real-world example of colleges using contact tracing and surveillance on their students to ensure faster responses as schools reopen. Because risk increases in the face of time delays, the value of eCR is high in these situations. Patient safety and having the right data, at the right time, to match the political aims are all important.
- **Abby Sears** described her experiences with eCR, noting that she has seen how it has allowed for the provider groups to reduce manual entry, which is similar to **Steven Lane's** comments. Also, she highlighted OCHIN's struggles to improve patient matching and noted that the matching rates were affected by equity issues (Latino and







Black populations are not matching at the same rates as the White population). Also, she noted her enthusiasm for strengthening the national framework for the movement of surveillance data beyond COVID-19 and noted that there are long-term opportunities. She thanked the CDC team and **Steven Lane** for their leadership and recent work.

- **Denise Webb** noted that her comment was related to the topic of patient matching that **Abby Sears** highlighted, noting that ONC conducted a recent listening session on the topic and is preparing a report to Congress with recommendations. She suggested that, in the interest of patient safety and quality of care, a recommendation be put forward to remove the ban, which is related to appropriations, on spending money to solve this problem.
- **Cynthia Fisher** highlighted the substantial loss of privacy that accompanies contact tracing and data sharing and noted that other countries might have a malicious intent to use this information as a form of terrorism. She requested that the HITAC recognize the amount of privacy that has been lost and that a plan to protect patient privacy should be put in place by the CDC and HHS.
  - **Robert Wah** thanked her for her comment and noted that the HITAC would examine the important topic of privacy in the future.

**Robert Wah** thanked the CDC presenters, noting that **Adi Gundlapalli** had submitted information in the meeting's chat feature. **Robert** explained that he would post an update on the Commons Project via the Adobe chat feature later in the meeting, in response to requests from other HITAC members.

## HITAC ANNUAL REPORT WORKGROUP UPDATE

**Carolyn Petersen** and **Aaron Miri**, co-chairs of the Annual Report Workgroup (ARWG), presented an update on the group's recent work. **Aaron** thanked everyone for the previous discussion and added that he hoped that they and their families were all safe and sound. **Carolyn** noted that she was looking forward to presenting the latest report on the ARWG's work and was anticipating feedback.

**Aaron Miri** presented an overview of the ARWG membership and ONC staff, meeting schedules and action items/deliverables for the ARWG and the full HITAC, and the next steps; all of this information was provided within the presentation materials. He thanked all team members for their work and encouraged everyone to send questions and comments to the ARWG co-chairs at any time. The next steps for the ARWG include developing the draft crosswalk of topics, including gaps, opportunities, and recommended HITAC activities across the target areas and presenting the crosswalk for discussion at the HITAC meeting on October 21, 2020.

**Aaron** lead a presentation and discussion of potential topics for the HITAC Annual Report for Fiscal Year 2020 (FY20). He summarized the following target areas and related topics, which included:

- Target Area: Technologies that Support Public Health
  - Exchange of clinical data for public health purposes
  - Privacy and security for public health purposes
  - Vaccine Tracking
  - Patient matching for public health purposes
  - International exchange of clinical data for public health purposes
- Target Area: Interoperability
  - Exchange of health data more broadly across the care continuum, e.g., for long-term post-acute care (LTPAC), behavioral health, and home- and community-based services (HCBS)





- Association between EHRs and patient safety
- Exchange of Social Determinants of Health (SDOH) data
- Increased health equity across populations, locations, and situations
- Sharing data with the research community
- Establishment of common metadata nomenclature and use
- Correction of incorrect data and the ramifications of exchange of incorrect data

**Carolyn Petersen** continued the presentation by summarizing the following target area and related topics, which included:

- Target Area: Privacy and Security
  - Protections for data generated outside of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Framework, including federal privacy laws and regulations beyond HIPAA
  - Privacy and security of synthetic data
  - Internet of Things (IoT)
- Target Area: Patient Access to Information
  - Patient-controlled data collection, access, and sharing

**Carolyn Petersen** noted that a number of topics were described in the landscape analysis and were carried over from the FY19 Annual Report. They included:

- Target Area: Interoperability
  - Federal activities including ONC Cures Act final rule and Trusted Exchange Framework and Common Agreement (TEFCA) program
  - Health information exchange (HIE)
  - Standards
  - Unique device identifier (UDIs)
  - Health IT support for opioid epidemic response
  - Patient matching and verification
- Target Area: Privacy and Security
  - International and state data exchange and privacy considerations
  - Cybersecurity
  - Machine learning and artificial intelligence in healthcare
- Target Area: Patient Access to Information
  - Use and sharing of patient-generated health data (PGHD)
  - Prescription of apps, i.e., digiceuticals

**Carolyn Petersen** noted that the ARWG has additional meetings scheduled over the next several months and invited HITAC members to attend at their convenience or to send feedback on the list of topics by email to herself, **Aaron Miri**, or **Lauren Richie**.

## Discussion:

- **Valerie Grey** submitted a recommendation to consider telehealth and its integration with EHRs and HIEs, as it is a timely topic due to the COVID-19 crisis. It could be included under the interoperability topics of interest.
  - **Carolyn Petersen** responded that this topic is in the landscape analysis and thanked **Valerie** for her support of the topic.





- **Aaron Miri** thanked **Dr. Donald Rucker** and the administration of the HHS for their work on the COVID-19 response efforts. He noted that many of the Annual Report topics intersect with topics those on the frontline have dealt with on a daily basis.
- **Carolyn Petersen** thanked the HITAC and reminded members to submit feedback on the list of topics by email.
- **Robert Wah** thanked the co-chairs for their work on the ARWG.

## INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE DRAFT RECOMMENDATIONS

### Introductions and Overview

**Sheryl Turney** and **Alix Goss**, co-chairs of the Intersection of Clinical and Administrative Data Task Force (ICAD TF), presented an update on the TF's recent work. **Sheryl** began by introducing herself and her co-chair and noted that she represents the HITAC, while **Alix** represents the National Committee on Vital and Health Statistics (NCVHS).

Then, **Sheryl** provided an overview of the ICAD TF's overarching charge and detailed charge, which were included in the meeting materials, and presented a list of TF members. She listed the presenters who have shared their expertise with the TF, including American Health Insurance Plans (AHIP), American Health Information Management Association (AHIMA), the American Medical Association (AMA), CAQH CORE, the Centers for Medicare & Medicaid Services (CMS), CoverMyMeds, the Electronic Health Records Association (EHRA), Humana, Premier Inc., Regions, Surescripts, and X12. She noted that, along with written input submitted to the TF, all of this information has been collected and is being used to craft the final report that the TF will present to the HITAC.

### Draft Report Work Process

**Sheryl** described the process of crafting the ICAD TF's draft report and presented an outline of the report, which was also included in the meeting materials. She noted that small workgroups formed within the TF, and some of the work they completed was on creating a basic clinical workflow diagram for a durable medical equipment (DME) prior authorization (PA) request. The TF has heard from various stakeholders on improving the PA process and reimagined an ideal state for the PA process, which included:

- An end-to-end, closed-loop process
- Reduced burden across all stakeholders
- Accounting for the vast majority of situations and leveraging existing investments and efforts where appropriate, acknowledging that there are indeed gaps

### Ideal State and Guiding Principles

**Sheryl** noted that the ICAD TF developed a series of Guiding Principles to frame and guide the TF's work toward their Ideal State and Recommendations. She described the TF's intentions and provided background information on each of the Guiding Principles, which included:

- Patient at the Center
- Measurable and Meaningful
- Aligned to National Standards
- Transparency
- Continuous Improvement
- Design for the Future While Solving Needs Today
- Real-Time Data Capture and Workflow Automation
- Information Security and Privacy





## ICAD TF Recommendations

**Alix Goss** thanked **Sheryl** for synthesizing the ICAD TF's four months of work and noted that the TF's work has focused on PA, but they have begun to discuss the broader intersection of clinical and administrative data. She presented their overarching Recommendations, noting that they were in no particular order and included policy levers to advance health IT certification frameworks as well as programmatic incentives and expectations for the government and the industry/private sector. **Alix** stated that the TF wanted to ensure alignment with current efforts and tools, including USCDI and FHIR, and described the considerations the TF took when building the list of Recommendations, which included:

- **Recommendation 1: Prioritize Administrative Efficiency in Relevant Federal Programs**
  - The task force recommends that ONC work with CMS and other Federal Agencies to work administrative efficiency objectives into relevant federal payment programs.
  - ONC and CMS jointly establish relevant certification criteria associated with the health information technology used to further administrative efficiency.
- **Recommendation 2: Establish a Government-wide Common Standards Advancement Process**
  - The task force recommends that ONC, working in concert with CMS and other relevant Federal establish a single consistent process for standards advancement for relevant standards for health care interoperability, including transactions, code sets, terminologies/vocabularies, privacy and security used for conducting the business of healthcare, irrespective of whether that business is clinical or administrative. To include multiple rounds of development testing and production pilot use prior to adoption as national standards.
- **Recommendation 3: Converge Healthcare Standards**
  - The task force recommends that ONC, working in concert with CMS, the National Library of Medicine (NLM), voluntary consensus standards organizations and other relevant federal agencies, harmonize standards to create a consistent set of standards for Code Sets, Content and Services that are evolved together to address multiple workflows, both clinical and administrative.
- **Recommendation 4: Provide a Clear Roadmap and Timeline for Harmonized Standards**
  - The task force recommends that ONC, working in concert with the aforementioned organizations, establish a clear roadmap and timeline for harmonized standards, following the common standards advancement process, including adequate pilot and production usage, to raising the national floor.
- **Recommendation 5: Harmonize Code and Value Sets**
  - The task force recommends that ONC work with CMS, NLM, and relevant value set authorities to harmonize code and value sets to serve clinical and administrative needs.
  - Where specialized code and value sets are needed, they must be mapped to more general underlying code and value sets. As an example, in order to streamline prior authorization workflows, the code and value sets used to encode orderables, procedures, or referrals must be reusable across or cleanly mappable or crosswalked to the code and value sets used to determine administrative authorization for payment for the relevant orderable, procedure, or referral.
- **Recommendation 6: Make Standards (Code Sets, Content, Services) Open to Implement Without Licensing Costs**
  - End-user licensing of adopted standards, code sets and vocabularies is burdensome. In order to drive innovation and make standards-based capabilities





available to the widest set of actors, the task force recommends that converged standards (and their included component code sets, etc.) named in certification programs be available to implementers without licensing costs for developers implementing the named standards.

- Ideally, such converged standards would be available via one of the business models that support full and open access to standards (e.g., NLM national licensing for code sets or standards development business models, such as those deployed for HL7 FHIR or Internet standards, that support member prioritization for the advancement of standards while making the resulting standards and implementation guidance available through broad usage licensing); alternatively, fair, reasonable and non-discriminatory licensing may be a requirement for production use or marketing claims of conformance.
- **Recommendation 7: Develop Patient-centered Workflows and Standards**
  - The ICAD Task Force discussed the critical importance of patient access and the involvement of the patient into key administrative workflows. These workflows define access to and reimbursement for care, and delays in these workflows are a key source of care delays and sub-optimal outcomes within the health care system. Accordingly, “Patient at the Center” must be a system design philosophy and built in from the ground up. The patient and caregivers must be at the center of administrative workflows and standards must be developed that involve the patient as a key actor. The Task Force believes such “administrative” information is part of the Designated Record Set (as it is patient-specific information used for decision making); if there is uncertainty on the inclusion of administrative workflows in the DRS, the Task Force recommends ONC work with OCR to clarify the status of administrative workflows under the access provisions of HIPAA.
  - The ICAD Task Force recommends that ONC work with other federal actors and standards development organizations to prioritize and develop administrative standards that are designed for patient access and involvement. Even “workhorse” administrative standards like eligibility, claiming and electronic EOB/remittance, that are traditionally considered provider to payer, should allow access through the same API frameworks already supporting API access; converged clinical and administrative workflows, including prior authorization, should be designed to support API access and patient engagement as a matter of course. As an example, benefits information provided to the provider via eligibility transactions should also be available (or more transparent? Since patients get benefit / plan package details) to the patient via APIs; the content and status of claiming/remittance should be available to the patient not only at the end of the process through the current EOB API, but throughout the process of claiming and adjudication.
- **Recommendation 8: Create Standardized Member ID**
  - The ICAD Task Force recommends that ONC work with CMS (for Medicare, Medicaid, Medicare Advantage and MADPs), OPM/FEBP and DOD/Tricare) to create and incorporate standards for member ID cards (following on INCITS 284-2011; reaffirmed as INCITS 284-2011 (R2016)). Alternatively, a virtual ID card could be permissible provided it complies with the INCITS ID card capability requirements and HIPAA privacy/security requirements. Standard IDs would reduce burden by supporting patient access, clinical and administrative automation, and transparency between member/patient, provider and plan. Member ID should be sufficient, along with HIPAA-appropriate levels of assurance, to reference patient-specific plan and product requirements like drug formularies and prior authorization.
- **Recommendation 9: Name an Attachment Standard**





- The ICAD Task Force recommends that ONC work with CMS and other federal actors to establish an attachment standard. In the short term, this standard should be the existing ASC X12 275 5010 EDI standard. Consistent with the previous recommendations, this standard should be evolved to the harmonized standards.
- **Recommendation 10: Establish Regular Review of Prior Authorization Rules**
  - The ICAD Task Force recommends that ONC work with CMS and other federal actors to establish consistent processes and guidelines for prior authorization rulesets to apply to CMS, MA, FEHP, and other similar federally controlled or contracted plans. Such processes should simplify rules, and remove rules that have high burden (e.g., those that are frequently approved, frequently overturned on appeal, or otherwise have low utility) and reviews should take place no less frequently than annually.
  - The ICAD Task Force recommends that ONC work with CMS and other relevant Federal actors to establish transparency in the Prior Authorization process via published metrics on authorization and denial rates, rates of appeal and metrics on appeals.
- **Recommendation 11: Establish Standards for Prior Authorization Workflows**
  - The ICAD Task Force recommends that ONC work with CMS, other Federal actors and standards development organizations to develop programmatic (API) specifications to create an authorization (electronic Prior Authorization or related determinations such as Medical Necessity) such that the authorization and related documentation can be triggered in workflow in the relevant workflow system where the triggering event for the authorization is created. As an example, when an authorization is required for payment for a procedure or referral for evaluation or treatment, the prior authorization workflow should be enabled in the relevant ordering or referral clinical workflow.
  - The Task Force recommends that ONC work with CMS and other Federal actors overseeing benefits plans (e.g., Tricare, FEHP) to establish policy mechanisms to provide or incent electronic prior authorization. The Task Force recommends these standards include sufficient guidance on operating rules, including service level objectives on latency and availability sufficient for prior authorization to be incorporated in interactive workflows.
  - The Task Force recommends that standards and implementation guidance specify requirements on denials such that denials are accompanied with clear, complete and computable reason for denial such that actors can correct, if relevant and applicable, causes for denial. The standards and implementation guidance should require any denial to address all deficiencies in the request, i.e., must evaluate the entire request and not simply issue a denial citing only the first in a potentially longer sequence of identifiable deficiencies.
- **Recommendation 12: Create Extension and Renewal Mechanism for Authorizations**
  - The ICAD Task Force recommends that ONC work with other federal actors and standards development organizations to develop programmatic (API) specifications to renew or extend an authorization where prior authorization applies to services that have long durations.
  - The Task Force recommends that ONC work with CMS and other Federal actors overseeing benefits plans (e.g., Tricare, FEHP) to ensure that authorizations can be renewed through these means without requiring a new authorization and that such renewals and the status of existing authorization be enabled via standards-based APIs.





- **Recommendation 13: Include the Patient in Prior Authorization**
  - The ICAD Task Force recommends that ONC work with CMS and other Federal actors administering health benefits (e.g., FEHP, Tricare, VHA) to ensure that prior authorization systems be designed with patient engagement as a critical design goal, such that the patient is included throughout the process.
  - The patient (or designee) should receive notification and status of key activities and have the ability to view content associated with the prior authorization (for informed decision making and correction) and provide patient-generated information into the prior authorization process (e.g., ability to point out errors and to respond to such questions, if any, which only the patient herself/himself can answer).

**Alix Goss** invited the HITAC members to submit feedback on the list of Recommendations.

**Discussion:**

- **Robert Wah** thanked the ICAD TF for their work and the co-chairs for the presentation.
- **Ken Kawamoto** thanked the ICAD TF co-chairs for the presentation and voiced his support for making standards available for free to the end-user. He discussed how the HITAC could support national resources and infrastructure to ensure that standards, like FHIR, are free and funded.
- **Clem McDonald** commented that the ICAD TF's recommendations were good but very ambitious and need more specificity, especially the recommendation to harmonize code sets and values. He discussed efforts by NCVHS to resolve differences in the clinical and business/insurance payment standards and suggested further interaction between the ICAD TF and the NCVHS committee to unify coding systems. Also, he voiced his support of **Ken Kawamoto's** comments that more base government support is needed to ensure that standards are free.
  - **Alix Goss** responded that there has been some synergy between NVCHS and the ICAD TF, as several members of the TF served on the standards subcommittee that looked at the overarching vocabulary library through a robust scan that was supported by the National Library of Medicine. She noted that the TF's full report will be presented to the HITAC for review and comment and will evolve. Once the report has been completed and submitted to the HITAC, it will also be sent to NCVHS and used to inform their work on vocabularies and code sets. She thanked Clem for his comments on specificity and noted that additional details will be provided in the report. The TF has worked to craft recommendations that push the envelope while not getting in the way of how things are done, and policy goals will be the next step. The TF will be sure to focus more concretely on the specificity aspect in the next version of the report.
  - **Clem** referenced X12 and HL7's history of joint work on creating an attachment standard and asked **Alix** if she was aware of that project.
  - **Alix** responded that she was very aware of this work and the industry's requests for an attachment regulation. The joint collaboration has been extended beyond the HIPAA realm to include FHIR, as well.
- **Carolyn Petersen** thanked the ICAD TF for the wonderful work and commented on the last recommendation that addresses the importance of the idea of keeping the patient at the center. She asked for more background information on work that has been done to ensure that patient-centeredness takes hold, going forward. She asked if there was any standards development or work scheduled with vendors and how patients and patient advocates could be more educated and engaged in furthering this work.
  - **Alix Goss** thanked **Carolyn** for her participation in several of the ICAD TF meetings and summarized the questions. Her responses included:
    - She noted that there are new technologies that use FHIR application





programming interfaces (APIs) to help the patient-facing standards, workflows, and capabilities be more integrated. The API capabilities and FHIR-based standards need to be improved and refined to enable easier data flows to meet citizens' needs, whether they are using computers, devices, portals, or other platforms.

- She explained that enabling patients and caregivers was a more complex process and noted that more complex patients have different and more complex needs. She suggested that the HITAC and ONC focus on educational materials that detail a patient's right, how they can get data, and tutorials but noted that not enough work has been done to help patients in this way. She encouraged additional feedback on patient-engagement-related activities.
- **Sheryl Turney** responded that there is a great deal of work to be done relative to these topics and described interoperability challenges faced by the patient/caregiver in the current health system landscape, including managing data in multiple apps, portals, and various electronic medical record (EMR) systems. She noted a lot of work to be done and described the challenges and burdens uncovered by the PA workflow modeling work the ICAD TF undertook. Overcoming these challenges will take time and will require policy levers and incentives to make interoperability easier. She discussed creating a maturity capability cycle and noted that prioritization has been discussed, noting that it is a broad subject with stakeholders with different priorities. The TF will work to keep the patient at the center of future discussions around the broader intersection.
- **Carolyn** thanked the co-chairs for the clarifications and detailed examples and asked about the role the ICAD TF sees for patients and patient advocates in developing technologies and standards that will lead to the Ideal State. She explained that many in healthcare feel that the current PA process works fine for patients and asked what is being done to ensure patients' interests remain at the center of future work.
- **Alix** thanked **Carolyn** for clarifying her point and replied that the ICAD TF has not discussed getting patients involved in standards development. She noted that it might be difficult to engage them in this way but suggested that patients could be viewed as a user group that could provide user-centered design as part of the development of products. The TF will discuss this topic at a future meeting.
- **Sheryl** thanked **Carolyn** for the comments and noted that the TF will discuss how to get patients more engaged in the process.
- **Arien Malec** noted that it has been a pleasure to participate in the ICAD TF and addressed **Clem McDonald's** comments about specificity, noting that the TF has been careful to walk a thin line when crafting their documents. Though FHIR-based APIs encompass both clinical and administrative transactions and would be a logical candidate for reconciliation, it is more important to establish a consistent process for the evolution of standards, which lack uniformity. The standards advancement process that ONC has promulgated, as well as commentary by the HITAC and prior committees, informed the TF's work on their recommendations; this is similar to the process that NCVHS has taken with CMS. He discussed the need to establish a roadmap for the industry as there are still many entrenched standards that will continue to evolve. The TF's perspective is that a consistent and common process must be established, including developing a roadmap for the industry, but the TF recognizes that a great deal of evolution and work is required. He noted that it's really important to get the standards advancement process and the underlying processes used by the relevant federal agencies correct up front and noted that getting that right will help the evolution towards a more common process. Finally, he echoed the others' comments about the patient as a key actor and incorporating the patient voice, even in the standards design process.
- **Clem McDonald** highlighted the issue of patients needing to go through several portals to access their data and discussed possible ways to connect the data, like a





mechanism in Google Chrome; a personalized URL a patient could use to transfer data to a personal records systems and to enable HIEs to serve the patient directly as a collection site or a “one-stop-shop” for their information.

- **Robert Wah** noted that the issue was tangential to PA, but, as it is part of the broader intersection conversation, asked the ICAD TF co-chairs if they would like to comment.
- **Alix Goss** responded that the current Patient Access and Interoperability Final Rule will help advance the situation **Clem** described. Also, as the API economy advances, she anticipated that patients and caregivers will be able to receive their data in the app of their choice in the future. As an example of how programmatic policy and health IT certification expectations can join in moving the marketplace, she discussed her experience serving as a consultant to the Da Vinci Project’s community round table where a payer and their vendor brought together three separate apps, which allowed the patient to request all of their information to one app on their phone. This intersection will advance but also needs to be monitored, going forward, to ensure that the patient is well served.
- **Sheryl Turney** noted that **Alix** summarized the topic well.
- **Robert Wah** noted that a discussion occurred in the meeting chat feature about CommonHealth, which is meant to make it easier and more transparent for patients to get their health data in one place.
- **Cynthia Fisher** noted her appreciation for the discussion on this topic and discussed the possibility for the patient to be able to take advantage of greater transparency to shop for PA across the marketplace, rather than being locked in with a specific provider. She noted that insurers should be aware of historical claims data and noted that a study by Vanderbilt found that cash prices in the same facility are about 40% lower than negotiated rates. A patient who wants to get a PA should have the freedom to shop, to compare cash and negotiated rates, and to be able to have new innovative models of saving money in healthcare. She stated that shared information span insurers, systems, and providers, and not be placed in one portal.
  - **Robert Wah** and **Sheryl Turney** thanked her for her comment, and **Sheryl** noted that the model of the app economy Cynthia discussed would require additional discussions around impact, in-network versus out-of-network providers, and other factors. The ICAD TF will examine and discuss this possibility.
- **Alexis Snyder** referenced **Carolyn Petersen’s** earlier questions about how to engage patients better. She noted that some of the content presented to the HITAC has been worked on by the ICAD TF for many weeks and noted that what was presented at the current meeting is only a small portion of the work, which will include additional details around the ideal state for transparency and patient engagement. She noted that she is a patient/caregiver voice on the HITAC and explained she has ensured that the TF’s documentation does reference involving the patient in the standards process and other recommendations. She described the TF’s work around transparency and not allowing the patient to access their data within various systems but also ensuring that the data, itself, is accurate and fully transparent. One of the topics both ICAD TF co-chairs highlighted is decreasing the burden on the patient to act as a go-between when systems are not working and information is not available. She discussed the work the TF has done on the role of transparency throughout the PA process and noted that the TF has discussed the overarching question of how patients can be more involved in the future, noting that they would not lose sight of the need to involve the patient in the standards process.

**Robert Wah** thanked the ICAD TF co-chairs for the presentation and commenters for submitting feedback. Then, he requested that the HITAC pause their discussion to begin the public comment period.



## PUBLIC COMMENT

**Lauren Richie** opened the meeting for public comment, and there were four public comments submitted by phone:

**Lauren Riplinger, AHIMA:** Thank you. Good morning, everyone. As the operator noted, my name is Lauren Riplinger. I am Vice President of Policy and Government Affairs for the American Health Information Management Association (AHIMA). AHIMA represents health information professionals that work with health data of more than 1 billion patients a year. I want to say that we greatly appreciate the work of the ICAD task force thus far, and wholeheartedly agree with the goal of integrating clinical and administrative data to reduce burden for patients and providers, as well as improve care and potentially reduce costs. That said, we would like to recommend that the HITAC provide an opportunity for stakeholders to offer input on these consequential recommendations, which have only been made public today, before they are submitted to the secretary. Certainly, while stakeholders have had, and we greatly appreciate the opportunity to provide general input to the task force, no one has really had an opportunity yet to provide specific input on these recommendations or to see the full narrative to describe and justify them. For example, some of the recommendations such as the development of federal incentives and changes to existing processes for setting standards need to be considered from multiple perspectives, particularly given the range of stakeholders that they could potentially impact. I'd also note, and I know Alix touched on this during her presentation, but we do want to underscore and ask the HITAC to just provide a little more clarity as to how they envision that coordination with NCVHS as you review and approve these recommendations. So, I want to thank the committee and the task force for their work on this important topic and thank you for the opportunity to provide public comment this morning.

**Robert Tennant, MGMA:** Thank you, yes. I'm Rob Tennant, I'm the Director of HIT Policy for Medical Group Management Association (MGMA), and I wanted to echo Lauren's comments. I think the work of the ICAD task force has been exemplary. I will say that MGMA members over the last few years during surveys have identified prior authorization as the leading burden facing practices today. So, this work is absolutely critical. I wanted to also agree that we need to have more opportunities to provide public comment. I think the example here would be the NCVHS predictability roadmap, which was put out for public comment, and I think was made stronger because of it. I think we also have to know a little bit more about how NCVHS is going to interact with many of these recommendations. A lot of them require extensive federal involvement, and I think it's important for us to know a little bit more about the pathway towards those. I also wanted to raise an issue about one of the guiding principles that I don't feel made it into the recommendations, and that is transparency. We would argue that prior authorization compared to other transactions is more like a conversation between providers and health plans. And if the two parties don't speak the same language, we're going to have a problem and I think that's one of the reasons why it is such a burden for everybody. So, I would recommend that the ICAD look at increasing transparency. And a lot of the recommendations are very complex and comprehensive. This one could be a low hanging fruit, and that is by requiring full transparency from health plans regarding whether a service or medication requires a prior authorization, how the payer supports prior authorization – for example, the 270-A, or portal, fax, or API. And finally, what clinical information does the payer require to adjudicate a prior authorization? Best case scenario would be of course the clinical template being available. That would help both providers and patient and would speed up the process. Thank you so much.

**Daniel Vreeman, RTI International:** Thank you. I want to commend the task force for their excellent work on this topic. I support the overall recommendations quite enthusiastically. I would like to emphasize and come back to a comment that Clem made in thinking about the language for Recommendations 3, 4, and 5. I guess I would encourage the task force to consider the verbs "converge, unify, harmonize" as you're thinking about these recommendations. They all have slightly different implications as far as the trajectory, and I recall some of the conversations in the NCVHS deliberations around this and the general principle of trying to sort of converge on or select sort of a particular terminology or code system per domain, meaning avoiding where possible the implications of mapping which becomes a sort of forever burden on everyone, as opposed to sort of consolidation. And so, I would just ask for further





consideration of that as you get towards the specificity that I think Clem was bringing up. Thank you. Overall, though, I wholeheartedly support.

**Heather McComas, AMA:** Hi there. Great. Thank you so much. And I'm glad they got through despite the confusion. I'm Heather McComas, Director of Administrative Simplification Initiative at the American Medical Association (AMA). I first want to echo the other commenters who have expressed their great appreciation for the task force's work over these many months. I know that in addition to the weekly calls that were visible to us, there was a lot of work going on in the background, so we really appreciate that. I also want to express AMA's thanks for being allowed to present to the task force earlier this summer, because prior authorization is such a huge priority issue for our members and also for patients.

And we also agree that it's important to integrate clinical and administrative data to reduce burden for patients and providers and prove care and we also think it has the potential to reduce cost. The comments we want to make today basically focus on process, similar to some of the comments you've heard from AHIMA and MGMA earlier in the comment period. These recommendations are wide ranging and ambitious and cover many different areas and quite complex. And they also could have many impacts on various stakeholder groups, including our member physicians but patients as well, and also standards development organizations. As others have referenced, there's things about federal incentives included in the recommendations as well as changes in the traditional standards development processes, and for this reason, we think as others have mentioned that it is important to offer stakeholders the ability to offer their full feedback on the recommendations.

We just got the chance to formally see them today and we greatly appreciate the fact that the task force did have a public comment period during all of their meetings, but the recommendations themselves are newly publicly released and so we feel that it's very critical that all stakeholders be able to fully review these recommendations and provide input to HITAC before they're finalized. It's also been referenced to we think that the supporting fuller report that I know the task force is hard at work be available for public review and comment as well because that will provide the justification and the background for these recommendations. So, we urge ICAD to make that public and for HITAC to allow stakeholders to comment on the full report, as well.

Finally, as others have mentioned too, we think it's really important that NCVHS and HITAC coordinate their efforts on these recommendations moving forward. I think it's been discussed some today, but I think it's not entirely clear how that's going to work. Obviously, there's been a lot of talk about harmonization and bringing things into alignment, and if at the end of the day these recommendations are taken in two different directions by two different bodies that could end up with disparate and unaligned results. In any case, we greatly appreciate all the work that both the ICAD and HITAC have done on this topic and we again hope we have the ability to fully comment on the recommendations. Thank you.

## Questions and Comments Received via Adobe Connect

**Lauren Richie:** Good Morning. We will begin shortly.

**Adi Gundlapalli (CDC):** Adi Gundlapalli from CDC here

**Elaine Hunolt - VHA:** HI Jonathan Nebeker may be joining by phone. We have VA representation on the public access. Glad to join!

**Lauren Richie:** Welcome Elaine

**Lauren Richie:** Hello Adi

**Adi Gundlapalli (CDC):** Hi





**Adi Gundlapalli (CDC):** on web only

**Robert Wah:** Here is the link to the Congressional testimony before the House Budget Committee  
<https://budget.house.gov/legislation/hearings/software-update-required-covid-19-exposes-need-federal-investments-technology>

**clem mcdonald:** got on about 2 minutes ago. Please log me as present

**Robert Wah:** Here is the video of the hearing as well <https://youtu.be/TWSNvj246iw>

**Ram D. Sriram:** @Lauren: Ram reporting

**Lauren Richie:** Hello Clem and Ram

**Denise Webb:** Does Laura have a list of the vendors/product that already support eCR beyond Cerner and Epic?

**Brett Oliver:** Also, eCR really saves infection control staff (and others) considerable time - can be a major selling point to healthcare organizations

**Aaron Miri:** Brett- you're exactly right. It would have saved us here at UT austin, weeks of work

**Andy Truscott:** Agree totally on eCR, and Steve's comment on regulatory support.

**Elaine Hunolt, VA:** How are public health agencies combining the document and FHIR messaging data they are getting?

**Steven Lane:** The data sent via CDA and FHIR all go to APHL where it is evaluated and routed on to the local health jurisdictions via their preferred method of receipt.

**Steven Lane:** See Slide 14 in presentation. Also note that the data exchange is bidirectional, with a Reportability Response being sent back to *[sic]* the reporting provider/organization.

**Steven Lane:** It would be GREAT to get VA onboard with eCR. :-)

**Adi Gundlapalli (CDC) 2:** Thank you all for the excellent comments and questions for eCR. We are fortunate to be able to present at HITAC on eCR again and have benefited immensely from the comments and partnerships fostered through HITAC

**Tina Esposito:** I have joined the meeting.

**Steven Lane:** All certified EHRs should have the FHIR capabilities necessary to support eCR.

**Steven Lane:** Public Health jurisdictions have reported that they receive eCR data more quickly and reliably than their eLR data feeds.

**Steven Lane:** eCR, while now being rapidly deployed to support COVID-19 reporting, is also capable of supporting case reporting of ALL reportable conditions.

**Jim Pantelas:** Has any dialog been had regarding using uniformed services to launch additional IT services within settings that are already stretched? My thought is that the community hospitals and services *[sic]* c providers are already stretched thin from an IT perspective, but this is a one-off type of





need that is just not built into their budgets. it's like asking everyone to be ready for *[sic]* a go-live need without a budget.

**Adi Gundlapalli (CDC) 2:** Thank you Steven for the support and expertise you have on eCR!

**Steven Lane:** Thanks to Abby Sears and OCHIN for contributing mightily to the eCR effort through the ongoing engagement and contributions of their CTO Paul Matthews.

**Carolyn Petersen:** Jim, that would be a good issue for a future discussion.

**Andy Gettinger:** Thanks Denise -- appreciate your comment on identity/patient matching. Andy

**Abby Sears:** i would argue that the lift is reasonable small on this and the impact for the current *[sic]* and long term implications *[sic]* are huge. providers are required to do this manually and this is much more costly *[sic]* and frustrating to providers.

**Robert Wah:** Thanks to those who have asked for update on Commons Project work. Things are going well. CovidCHECK where I am the Executive Director, has been deployed now in 9 languages and is being used globally and in Back to Work/School applications in US. Common Health, the Android version of the iOS Apple Health has also been deployed and is being rolled out with major academic medical centers so individuals can now download and store their health information on their mobile devices. The latest is Common Pass that allows individuals to access their info on CommonHealth/AppleHealth and then display their status (COVID related) for travel and international border crossing. This work is being done with World Economic Forum, IDEO and many governments internationally. A pilot is being planned for use in NYC-London corridor travel for month of September. More information is available at [www.commonpass.org](http://www.commonpass.org)

**Leslie Lenert:** Amazing work--what a coalition you've assembled!

**Steven Lane:** @ Robert - Can you share any metrics re numbers of live sites, users, numbers of uses, volume of data accessed/exchanged/used?

**Robert Wah:** @Les-Thanks! It is amazing seeing the coalition come together. We had over 350 on a call from around the world talking about Common Pass.

**Ken Kawamoto:** Note that NLM/federal government does NOT provide a national license for FHIR. It is unclear the approach is sustainable without federal support.

**Robert Wah:** @Steven I assume you are asking about Common Health. It is fairly *[sic]* new and is the Android version of Apple Health. Just like Apple Health, we are rolling *[sic]* out with Academic Medical centers starting at UCSF. The tech is in place to access data from Epic and Cerner systems and plan is to roll onto additional AMC's over next couple of months. VA is also close to finalizing connections.

**clem mcdonald:** robert, are they following the same FHIR *[sic]* and coding standards as Apple health has chosen, that would be great if they did

**Alexis Snyder:** lost phone connection-calling in again but operator not answering *[sic]*

**Robert Wah:** @Clem-Yes, following same FHIR path as AppHealth

**Don Rucker:** Thank you for all the work going into the recommendations!





**Steven Lane:** @Robert - We at Sutter Health (not academic) are also now in process implementing CommonHealth. Will be very interested in seeing posted/published metrics for any/all of the products once those are available.

**clem mcdonald:** I can't get to the unmutre [sic] - take another question and I will figur it [sic]

**Robert Wah:** @Steven-Great to hear about Sutter joining in the fun! Common Project/Common Health is a nonprofit, 501C3 org so we are pedaling as fast as possible doing implementations; will get the metrics out as soon as possible.

**Aaron Miri:** Steven - would love to learn how it goes at Sutter. I'd like to look at here if there's applicability [sic] to my population

**Steven Lane:** @Robert - Looking forward to CommonHealth being upgraded to be able to access, exchange and use all USCDI data elements including clinica [sic] notes. Apple Health doesn't seem to be able to request clinical notes yet. The [sic] EHRs are increasingly able to respond to queries for full USCDI and providers are responsible for responding with this data whern [sic] requested beginning 11/2/2020. I understand that CommonHealth will be ready to request the data by then. Looking forward to seeing this revolutionary step forward in information transparency.

**Robert Wah:** @Aaron-We believe it is straight forward getting CommonHealth connected. @Steven Yes, we are mindful of the clinical note issues and the 2 Nov 2020 date. We are doing this to provide individuals greater access to their health information. We can all see the benefits of that access and the use of the information

**Aaron Miri:** @robert - I'm sure it is. I just mean how it goes with the patients. When we rolled out apple healthkit, [sic] suddenly it forced our docs to become tech support as well and ... that didnt [sic] go over well. Patient technical literacy has to become a key component of education efforts and further health equity.

**Rich Landen:** Another path/tool for patient involvement discussed in ICAD is leveraging federal programs (Medicare, MA, VA, DoD) to take the lead to incorporate new patient touchpoints as Program Requirements rather than going the HIPAA or CURES direction of promulgating regulation.

**Carolyn Petersen:** Thanks, Rich. I'd be interested in hearing more about that.

**clem mcdonald:** If it is possible could I comment on the recent discussion about the fact that patients have to go to many sourcces [sic] to pull [sic] their data together. That can't be blamed on or fixed by the individual systems by themselves. There are other solutions.

**Robert Wah:** @Aaron-Ah, yes the patient education side is important. We hope to learn from what went well and what did not go so well with Apple Health and improve the processes for Common Health

**Robert Wah:** @Clem-We are hoping Common Health can help in pulling info from multiple sources. We have got connections with Epic, Cerner, Quest labs and Lab Corp to get info onto individual's personal device in one place.

**Aaron Miri:** @robert - Goes back to the eCR discussion earlier. I'm hoping the other vendors other than the usual progressive EHR companies step up and offer integrations...

**Steven Lane:** Carolyn & Robert - It would be nice to take some time for the ONC team to provide an update on our progress toward the implementation of and compliance with the new Cures rules. Specifically I'd love to know when they anticipate publishing FAQs regarding the Information Blocking prohibition as many providers have persistent questions about just what they need to do and how they





should configure their systems for compliance. I believe that well-crafted FAQs, published soon, could go a long way toward addressing many of the outstanding questions.

**Alexis Snyder:** I am unmuted not sure why not working

**Alexis Snyder:** does operator not have me in talk mode

**Brett Oliver:** I echo Steven's suggestion. Not much time left to educate our providers on the impending IB rule

**clm mcdonald:** I have to be at an NLM meeting at noon. So apologies for leaving

**Steven Lane:** PriorAuth transparency should include the individual/patient who deserves to truly understand why their procedure was/was not approved.

**Aaron Miri:** @ steven - i'd [*sic*] agree but also add it should be in language easy to understand for the patient and not some pre-canned terminology that only a billing coder can understand

**Margaret Weiker:** NCPDP supports the comments made by AHIMA.

**Laura:** I think Heather McComas from the AMA is trying to make a public comment

**Heather McComas:** AMA supports AHIMA and MGMA comments. I am on line for public comment -- not sure why not called on -- ?

**James Ellzy:** Sorry to have joined so late this morning. Had a conflict VA/DoD/FEHRM meeting I was required to attend.

**Margaret Weiker:** NCPDP supports the comments of the AMA.

**Alix Goss:** Thank you Margaret.

**Sheryl Turney:** ICAD meets weekly 3-4:30 pm ET each Tuesday [*sic*]

**Sheryl Turney:** we welcome your participation and comments

Following the public comment period, the ICAD TF co-chairs resumed their presentation.

## **ICAD TF PRESENTATION & DISCUSSION, CONTINUED:**

In response to earlier comments made by HITAC members, **Alix Goss** provided an overview of work completed by NCVHS on their predictability roadmap and noted that it was an extensive and non-typical effort that had a well-defined set of questions, background documentation, and 23 recommendations that were put forth. This work resulted in 23 letters, including recommendations, that were created and sent to the federal audience by the Secretary of NCVHS. The TF has worked closely with ONC and NCVHS to bring together the industry on this topic, and, instead of holding dual hearings, the work of the ICAD TF will inform NCVHS's convergence process. Then, NCVHS will collaborate with ONC to determine which actions are advanced under each agency's authority, and **Rich Landen** (ICAD TF member) will be involved, moving forward, as he is a member of the ICAD TF and **Alix** is co-chair on the NCVHS Subcommittee on Standards.

**Alix** responded to feedback from those who were able to examine the full document and explained that the ICAD TF has been working to synthesize all of the presentations, models, TF work, feedback, and





questions from the past few months into a final draft document. Work is still underway on the document as the TF discusses the broader intersection of clinical and administrative data.

**Robert Wah** thanked both co-chairs of the ICAD TF, **Alix Goss** and **Sheryl Turney**, for their work and noted that he looks forward to the opportunity for the two committees to coordinate as the report goes forward.

**Sheryl Turney** thanked the public for submitting comments and noted that the ICAD TF would discuss them at their next meeting. She explained that the information presented at the current meeting was only a small summary of the recommendations, noting that additional information related to establishing greater transparency around PA requirements is included in the longer report for Recommendation 11, and apologized that the presentation was not clearer in that regard. The HITAC will be given the opportunity to submit further input.

**Arien Malec** addressed the comments on the transparency of the report, stating that every meeting of the ICAD TF is open to public comment. As the TF assembles the final report, he welcomed members of the HITAC and the public to submit feedback on the report during the public comment period. All materials will be made available, and he discussed the process by which the report will be transmitted to the National Coordinator and Secretary of HHS and acted upon by these parties in the future. He voiced his appreciation for the feedback that has been submitted and encouraged additional input.

**Robert Wah** thanked **Arien Malec**, **Sheryl Turney**, and **Alix Goss** for their comments and for their work as members of the ICAD TF. Also, he thanked everyone for the robust discussion and encouraged members to attend the next meeting of the TF.

## WRAP-UP AND FINAL REMARKS

**Lauren Richie** reminded all members and listeners that the next meeting of the ICAD TF would take place on September 15, 2020, so there will be more time to review their suggestions. She reminded HITAC members that if they were interested in serving as a co-chair, they should email her. Draft recommendations and other materials from the meeting are posted on the [HealthIT.gov](https://www.healthit.gov) website.

**Carolyn Petersen** thanked the HITAC members for attending and for contributing to the rich discussions around eCR and the ICAD TF's work. Also, she thanked all of the presenters for their time.

## ADJOURN

**Lauren Richie** reminded members that the next meeting of the HITAC will take place on October 21, 2020.

**Robert Wah** thanked everyone for their participation, and the meeting was adjourned at 12:20 p.m. ET.

