Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

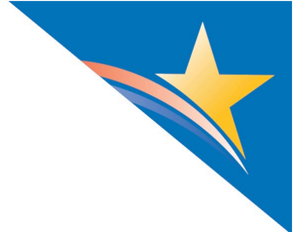
HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTEROPERABILITY STANDARDS PRIORITIES TASK FORCE 2021 MEETING

June 24, 2021, 2:00 p.m. – 3:30 p.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Arien Malec	**Change Healthcare**	**Co-Chair**
David McCallie	**Individual**	**Co-Chair**
Ricky Bloomfield	Apple	Member
Cynthia Fisher	PatientRightsAdvocate.org	Member
Valerie Grey	New York eHealth Collaborative	Member
Jim Jirjis	HCA Healthcare	Member
Edward Juhn	Inland Empire Health Plan	Member
Ken Kawamoto	University of Utah Health	Member
Victor Lee	Clinical Architecture	Member
Leslie Lenert	Medical University of South Carolina	Member
Ming Jack Po	Ansible Health	Member
Raj Ratwani	MedStar Health	Member
Ram Sriram	National Institute of Standards and Technology	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Wanda Govan-Jenkins	Office of the National Coordinator for Health Information Technology	Staff Lead
Denise Joseph	Office of the National Coordinator for Health Information Technology	Staff Lead



Call to Order/Roll Call (00:00:00)

Operator
All lines are now bridged.

Mike Berry
Great, thank you very much and welcome everybody. I am Mike Berry with ONC, and I would like to welcome you all to the Interoperability, Standards and Priorities Task Force. We really appreciate you joining us today. I am going to open up today's meeting with roll call and I will start with our co-chairs. Arien Malec.

Arien Malec
Good morning. Afternoon.

Mike Berry
David McCallie.

David McCallie
Hello, good afternoon.

Mike Berry
Ricky Bloomfield.

Ricky Bloomfield
Good morning. I am here.

Mike Berry
Cynthia Fisher. Valerie Grey. Jim Jirjis. Edward Juhn. Ken Kawamoto.

Ken Kawamoto
Morning.

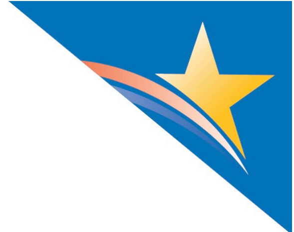
Mike Berry
Victor Lee.

Victor Lee
Present.

Mike Berry
Leslie Lenert. Clem McDonald. Jack Po.

Jack Po
Here.

Mike Berry
Raj Ratwani. Ram Sriram.



Ram Sriram
Present.

Mike Berry
Sasha TerMaat. Andy Truscott. Okay. If I missed, you I will catch you in the attendance queue and I would like to now turn it over to Arien and David. Kick us off.

Introductions (00:01:19)

Arien Malec
All right. We have another exciting meeting. So, we took the feedback and the testimony from our last meeting, as well as the discussion we had on recommendations and memorialized them into a set of updates to Recommendation 3. I am tempted to say things about the content of those updates, but I will not jinx ourselves by claiming anything about those updates. So, we are going to go through the updates and edits. We posted those updates to the full task force and solicited any feedback and certainly, invite participation from the task force members for going through these updates today. We will follow our usual process of looking at the changes. Providing commentary relating to the changes and soliciting the task force for full discussion and commentary relating to those updates with a goal. I will not say hope, with a goal of closing our final recommendations for submission to the full HITAC and not having to meet again. To be able to go over this prior to the July meeting. David, anything you want to add prior to just diving into it?

David McCallie
No, let us take a look at the document.

Discussion of Updating Recommendation #3 (00:03:10)

Arien Malec
Okie-doke. I see that we have got the draft recommendations text all keyed up. So, if we can flip over or however, we wanted to handle this.

David McCallie
Yeah, I do not know if we can do that.

Mike Berry
No, **[inaudible] [00:03:31]** will pull it over for us.

Arien Malec
Okay. Perfect.

David McCallie
Yeah.

Arien Malec

All right. Here we go. So, we made some updates to the front matter, primarily to simplify the front matter that we are really focusing on, recommendation in the free. Provide a little bit of a history and provide an update to the testimony that we had last week. We can go over that if the task force members desire to. But we thought we would dive into, this is high level recommendation level, No. 3. So, this is the executive summary recommendation and then we can go through all the detailed recommendations. So, you can see No. 1, that we added, in order to improve our interoperability innovation, as well as maximize and deploy the HR base for pragmatic research as an add. We footnoted ONB Circular A1-19 as well as NCVHS Vocabulary Recommendation. We attempted to be consistent in the terminology, 2019 STDHS vocabulary recommendations. That was just by way of editorial consistency. We changed open to free or low cost to be consistent with the language of the NCVHS, 2019 NCVHS Vocabulary Recommendations.

Then we added terminology curators. Removed a bunch of the detail around federal stakeholders to simplify this recommendation. Then we discuss in the detailed recommendation many of the means. So, we simplified this language just to say, align national terminology with this policy. So, most of this was by way of making the high-level recommendation simpler and more consistent in aligning with the consistency of terminology and adding footnotes with references to the source material. So, I am going to pause here and see if there are any comments on the changes here. Okie-doke. Hearing no changes, or hearing no comment, then we can go onto the meat of Recommendation No. 3. So, no. 1 is, we added a little bit more of the why, and context for the why. In particular, added that the task force recognizes professional maintenance of both vocabulary standards require work that needs to be funded.

We call out in parallel with the recommendations of NCVHS, we know that broader interoperability calls for an approach to sustainability for terminology creation duration, while also maximizing interoperability, patient engagement and innovation. It depends on various **[inaudible] [00:07:03]** health. Then note that we are providing recommendations that link to the 2019 NCVHS Vocabulary Recommendation. Again, re-footnote those vocabulary recommendations. David, you have a comment here.

<u>David McCallie</u>
Yeah, despite the fact that many eyes read this carefully, we left out the word for in broader interoperability calls for an approach to sustainability.

<u>Arien Malec</u>
Yes, we certainly did.

<u>David McCallie</u>
Does not change any meaning, but we missed it despite the fact that we read this thing so many times.

<u>Arien Malec</u>
Yep. This is, as everyone knows, the worst editors are the ones who labor over the writing, because we know exactly what we had meant to say. So, we will make that edit. Any other commentary here? Cool. Let us go on to the next section. So, we are consistent with federal stakeholders and terminology curators and our language throughout. We reference both A1B Circular, A1-19 and the 2019 NCVHS Vocabulary Recommendations in our first bullet point. Pause there. Okie-doke. Let us go on to Sub-Bullet I-I. So again, consistently throughout, we strike open and add free or low-cost use and then we provide cross reference to the language. It being 2019 NCVHS Vocabulary Recommendations. Our Recommendation B provides

all of our content and gloss of how, so we really keep Sub-Bullet I focused on the what by striking through national licensing or funding where appropriate. No change to Sub-Bullet 3.
On Sub-Bullet 4, we note that our call for international cross out to international standard is very much a, where available statement. So, we are not calling for the absurd like, do not use RX Norms because it is not an international standard, where there are no international standards. So again, I think that is just by clarity of that explanation. So, I will pause there and see if there are any comments on these updates. Hearing none. In our next section again, we used consistently terminology curators throughout. We make sure that we have got the, but not limited to, licensing terminology, funding terminology curators working. So, mostly editorial statements here. Managing transitional internalized standards, taking reasonable effort to minimize work related disruption during any transition. So again, some of this language came from other stakeholders. To be clear, we have called for reasonable efforts to minimize workflow disruption.

I think some alternative language ensuring that there is no workflow disruption and I think as we saw in the ICD10 to ICD11. Sorry, the ICD9 to ICD10 transition and as we will see in an ICD10 to ICD11 transition, we are going to have the need to change terminology standards. There is no non-workflow disruptive way of doing that change, but we need to contemplate methods that minimize the workflow disruption. So, I am going to pause here on Important Sub-Bullet B and see if there is any feedback. Clem, you have got your hand up.

Clem McDonald
So, it is a comment on the workflow disruption question issue which, I think it is good to have it in there, but I think kit might be quite possible that we will get a little workflow disruption from 10 to 11. I emphasize possible. I think there is some discussion and examination and analysis, and I think if a couple more modifiers could be added to ICD11, there are some who think they could have a perfect mapping, or a very good mapping.

Arien Malec
Clem, I am confused to whether you are suggesting changes here. So, my comment on ICD9 to ICD10 more by way of saying, in some cases, there is no way to do a vocabulary update that has zero workflow implications. So, we should take pains to make sure that we are minimizing the workflow **[inaudible – crosstalk] [00:12:11]** yes.

Clem McDonald
No, I was just responding to your comment more than the text so, never mind.

Arien Malec
Got you. Cool. Thank you. Awesome. Okay. Let us to go three. Sorry, C. The only thing that we did here was remove the word terminology, just because we are standardizing clinical results. Then pushed our inconsistent throughout. We pushed our cross reference to a footnote. Everything else here comes from Clem’s really helpful update to this point that we reviewed last meeting. Ram has a comment on how do we ensure if lab results are communicated properly. Ram, I would provide maybe a note that Clio already requires testing of results distribution to ensure clinical compliance. Our previous incarnation, the ISP Task force, made many detailed recommendations particular to this. So, here we are just making sure our recommendations here are limited to making sure that we facilitate use of Lynx, SNOMED and UCAN by making sure that we have requirements for upstream, as close to source as possible as opposed to what

we normally do, which is normalize downstream in some cases. Okay. Hearing no comment for Sub-Bullet C. Let us go on to D. So again, just being consistent with terminology curators.

Then E is mostly clean up to clarify intent. The transition ICD11, work with CMS and NLM to encourage harmonization, to allow a single nomenclature for capturing and coding problems and diagnoses. That is correct. For capturing and coding problems and diagnoses, clinical research and administrative workload, full stop. So again, the intent here is to get to singular vocabulary associated with problems and diagnoses and try to make sure that we are focusing on policy and not the **[inaudible] [00:15:05]**. So again, open for comment. I believe those are all the edits that we had to review today. We have put together, by we, the ONG Team put together a slide deck for the full high-tech consideration that just walks through the same edits that we just walked through. I am going to pause to see if there is any meta commentary. Any objections to passing these recommendations through to the full HITAC. Just make sure that the task force can fully enthuse the task force members who are part of the HITAC and fully and enthusiastically concur with our passing through these recommendations to the full HITAC.

Clem McDonald
I think you have done enough work. You need to get finished.

Arien Malec
Thanks, Clem.

Clem McDonald
You worked hard.

Arien Malec
Yeah. I do feel like the resulting language is cleaner and more consistent and net a better set of recommendations. So, the two meetings that we did I think, add up to a set of recommendations that Nikki can read and have no ambiguity associated with them.

Clem McDonald
So, can we call it a day?

Arien Malec
I hope we can. We do have to follow our obligation for public comment. If there are task force members who have any additional comment, welcome it. Otherwise, I think we should go for public comment and pass these recommendations on to the full HITAC.

Public Comment (00:17:17)

Mike Berry
All right sounds good to me as well and we will pause after the public comment period just to make sure none of the task force members thought of a comment they would like to add. But in the meantime, Operator, can we please open up the line for public comment?

Operator

Yes. If you would like to make a comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your line from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. Our first comment is from Laurie McGraw with the American Medical Association. Please Proceed.

Laurie McGraw

Thank you. This is Laurie McGraw, Senior Vice President, Health Solutions with the American Medical Association. We understand that questions related to AMA's licensing framework for CPT were raised during the task force meeting previously and wanted to offer some following clarifications. In the previous task force meeting, as stated by Dr. Peter Hollmann who spoke to this task force, CPT codes are multipurpose in meeting the needs of clinical and administrative workflows and integral to treating patients, supporting research and public health. For example, with COVID, CDC and CMS came to the CPT editorial panel with ideas for COVID vaccine and vaccine administration codes to support these agencies' tracking requirements. Users of CPT benefit from the level of trust in CPT because the CPT process is evidence based, transparent and driven by stakeholders. AMA ensures that obtaining a license to access the CPT code set is low cost and efficient, which meets regulatory requirements.

AMA makes the code set available on a nondiscriminatory basis to all interested parties. Typically, developers of products that use CPT codes obtain a license from the AMA and that license provides for access to users of such products. At an organizational level, some entities, technology developers, payers for example, obtain a license to use CPT broadly. This approach to licensing is common for organizations that create widely adopted intellectual property because it is efficient while reasonably protecting their rights. The AMA does not require patients or consumers to obtain a license. Further, the AMA has permitted a number of royalty free use cases to support patient participation in their care, price transparency, interoperability and innovation. Thank you for allowing me to make these comments on behalf of AMA.

Arien Malec

Thank you very much and much appreciated.

Operator

There are no more comments at this time.

Mike Berry

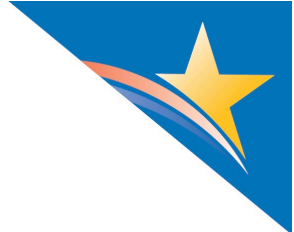
Great, thank you.

Arien Malec

All right. Let us have one last call for task force members. Then we will promote these edits as recommendations to the full HITAC for consideration for passing through to the national coordinator. Great work everybody and yeah, go ahead David.

David McCallie

Just provide my thanks to everyone who showed up and provided input and feedback to us. Extremely helpful and useful and a pleasure to work with everyone.



Arien Malec
Yeah, absolutely. As I said, I do believe that the resulting recommendations are all the better for the extra eyes that we had on it. So, thanks everybody.

Mike Berry
All right, thank everybody and we are adjourned.

Arien Malec
Thank you.

Clem McDonald
Thank you.

David McCallie
Bye-bye.

Adjourn (00:21:10)