



Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) EHR REPORTING PROGRAM TASK FORCE 2021 MEETING

August 25, 2021, 10:00 a.m. – 11:30 a.m. ET

VIRTUAL



Speakers

Name	Organization	Role
Raj Ratwani	MedStar Health	Co-Chair
Jill Shuemaker	American Board of Family Medicine's Center for Professionalism & Value in Health Care	Co-Chair
Zahid Butt	Medisolv Inc	Member
Jim Jirjis	HCA Healthcare	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Joseph Kunisch	Harris Health System	Member
Steven Lane	Sutter Health	Member
Kenneth Mandl	Boston Children's Hospital	Member
Abby Sears	OCHIN	Member
Sasha TerMaat	Epic	Member
Sheryl Turney	Anthem, Inc.	Member
Steven Waldren	American Academy of Family Physicians	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Seth Pazinski	Office of the National Coordinator for Health Information Technology	Director, Strategic Planning & Coordination Division
Cassandra Hadley	Office of the National Coordinator for Health Information Technology	ONC Staff
Michael Wittie	Office of the National Coordinator for Health Information Technology	ONC Staff Co-Lead
Dustin Charles	Office of the National Coordinator for Health Information Technology	ONC Staff Co-Lead
Fredric Blavin	Urban Institute	ONC Contractor
Mary Beth Kurilo	American Immunization Registry Association	Presenter
Eric Larson	American Immunization Registry Association	Presenter





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

Operator

All lines are now bridged.

Michael Berry

And, we are really excited to have everyone back with us today. We have a lot to cover, and we do have some special guests with us today that we will introduce shortly, but we are going to get started with roll call, so when I call your name, please indicate that you are present. I will start with our co-chair, Jill Shuemaker.

Jill Shuemaker

Good morning, everyone.

Michael Berry

Raj Ratwani, our other co-chair, will not be able to join us, but he will be back with us next time. Zahid Butt? Jim Jirjis? Bryant Karras?

Bryant Thomas Karras

Good morning. I am here.

Michael Berry

Joseph Kunisch? Steven Lane?

Steven Lane

Good morning.

Michael Berry

Ken Mandl? Abby Sears?

Abby Sears

Present.

Michael Berry

Thank you, Abby. Sasha TerMaat will be joining us later. Sheryl Turney?

Sheryl Turney

I am here. Good morning.

Michael Berry

And, Steven Waldren?

Steven Waldren

Here.





Michael Berry

Great. Thank you so much, and I will turn it over to Jill to get us started. Thank you.

**Opening Remarks & Draft Recommendations Report and HITAC Meeting Slides
(00:01:19)**

Jill Shuemaker

Great. Thank you, Mike, and welcome, everyone, and thank you for joining us on a Wednesday and making that little adjustment this week. We have a lot of slides to cover, so we are just going to jump right in. Next slide, please. So, what we are going to be doing today is we are going to review the agreed-upon recommendations. So, from the Google doc, Raj and I pulled over all of those pieces that we have agreed on for each of the measures, and with the Urban team's help, we have placed them into the slides. We are going to review those today. And then, there are some outstanding pieces around the public health information exchange measures. We have a guest speaker that will be presenting today, and if we have time, we will talk about those pieces that we had targeted that would be recommendations for further discussion. Then, we will go to our public comment and final remarks, and then we will adjourn. Next slide, please. Next slide, please. Next slide, please. Next slide, please. Next slide, please. Next slide. Next slide. And, next slide. Great, thank you.

So, this is just an outline of what our slides will look like or be involved for once we send them to the HITAC group. The introductory slide will contain all of those pieces that we just skipped over: Our charge, our roster, and our process overview. And then, we will go into the high-level summary of measures that we reviewed, and then, the next section will be the recommendations and our summary. So, that is the piece of the slide deck that we are going to cover today. Next slide, please.

So, to begin with, this is a high level. So, as you remember, we are reviewing each of the measures. We began to see that there were redundant messages that were going across all of the measures, and we decided to pull all of those out instead of repeating them with each measure into part of the slide deck that would say, "This is our recommendation cutting across all measures." So, I am going to give you a moment. I am just going to pause. I am not going to read each of these slides as we go through, but I just want you to review them, and if you have any comment, just raise your hand and comment on them. Otherwise, we are just going to keep going through the slide deck. So, again, these are cross-cutting recommendations.

Steven Lane

We also had some recommendations about provider encounter definitions. I do not know if you want to capture those here or not.

Jill Shuemaker

Yeah, there is another slide. This is actually two slides, and we can... Yup, there you go. I think that is what we captured on this slide. Is that what you were asking about?

Steven Lane

Yeah, just providing some more detailed definitions.

Jill Shuemaker





Yeah. Okay, any comments about the cross-cutting recommendations?

Steven Lane

Sorry, but I am not a coding deep expert, but I know outpatient encounters are also coded in CPT, and not exclusively in SNOMED.

Steven Waldren

Yeah, this is Steve Waldren. The parent **[inaudible] [00:05:12]** should be switched.

Jill Shuemaker

Okay. So, Steve, you are saying the SNOMED should be inpatient and the CPT should be outpatient. Is that correct?

Steven Waldren

That is correct.

Jill Shuemaker

Okay, we will make a note of that. Thanks for catching that.

Bryant Thomas Karras

It depends on what message type.

Steven Lane

This is encounters. We are trying to define the list of encounters that would count for the metrics. I thought the encounters followed CPT. I may be wrong.

Jill Shuemaker

Just as a reminder, as we were going through the measures, there was a question about who is included in the denominators, and so, we tasked Zahid and Steve to take a look at that, take a deep dive, and see if there were codes that we could use, and this was the recommendation that they brought forward, and we did agree on it, but if there is a question now, we can talk about it. Now is the time to talk about that.

Steven Waldren

This is Steve Waldren. One quick is Sasha... So, on our last call, just to recap quickly, Zahid and I thought it made sense to have simple definitions of the most common **[inaudible] [00:06:43]** we have created those two lists, and Sasha brought up the issue of specialty EMRs that may have certain things, like if they are especially focused on procedures, they would not be able to have encounters in those lists. So, her recommendation was to actually make them very expansive in order to make exclusionary lists as opposed to inclusionary lists, and we ran out of time to get a group to get a firm definition of who wanted to go that way, and Zahid and I have not had the chance to go in and find any value sets that we would recommend if we want to go with the more expansive definition of "encounter."

Jill Shuemaker





So, at this time, Steve, if I am understanding correctly, because you were coming in and out there, you and Zahid have not had a chance to talk about a definitive definition, and so, right now, we do not have... So, this recommendation is not really what we are saying. Is that correct?

Steven Waldren

Yes.

Jill Shuemaker

Okay.

Steven Waldren

And, there was discussion at the last meeting that there was not yet consensus on that, that we should have a different definition.

Jill Shuemaker

Okay. So, I think right now, we just need to note... Tell me if I am misunderstanding, but it sounds like the recommendation is that it needs to be defined, but right now, we do not have a definition to recommend. Is that correct?

Steven Waldren

I believe that to be correct.

Jill Shuemaker

Okay. All right, we will note that. And then, Steve, if you had Zahid get together this week, let us know because we will be reviewing some outstanding items next week, but that is our last week that we are going to be able to make any changes to the slide deck, so if you do touch base and you have a recommendation, please bring that forward to us so we can include it.

Steven Waldren

Will do.

Jill Shuemaker

All right, next slide. These are our recommendations for the patient access group of measures, and this one specifically is for the measure of the use of different methods for access to electronic health information, and again, I will just give you a few seconds to review that, and these were the agreed-upon items that we pulled over from the Google doc.

Steven Lane

So, in the section on provider-facing apps, we talked about at least attempting, if possible, to aggregate by product, but knowing that sometimes, that was not going to make sense, and I guess maybe we captured this... I think I would just include "aggregate by product where possible." That is the one bit of text I would add.

Jill Shuemaker

Okay. Any other comments around that piece? Is everybody okay with adding that?





Steven Waldren

I can agree.

Jill Shuemaker

That makes sense? Okay.

Jim Jirjis

Are we using the hand raise?

Jill Shuemaker

That is helpful, but if you have a burning thing, feel free to talk if no one is talking. But, if you want to identify yourself too, that would be helpful.

Jim Jirjis

Jim Jirjis here. One of the things we have been chatting about as we see this is Bullet No. 2, an active patient being one that had an encounter within the reporting period, and the only question we had was if, over time, we are thinking that the models of care will shift to substitution of online encounters through some of these apps for physical encounters, in value-based care projects, there may be incredibly valuable uses of these assets, these apps that will be missed by making the denominator just be a patient who has had an actual encounter. And so, one question was do we not also want to measure patient use of apps when we have successfully avoided encounters? Would we accidentally leave off insights into that valuable substitution in the near future?

Jill Shuemaker

Yeah, I think...not specifically to this active encounter, but some of the measures, there was conversation around how we cannot measure what we cannot capture, and so, if there is an encounter that is not happening because it was a good thing, that we kept them out of the office, there would be no way to capture that.

Jim Jirjis

You could, because for example, if you had an app... If it is the EHR reporting program, then if I have a diabetes or wellness app or something where a patient is just checking their weight, blood pressure, et cetera, and they log on, why would the FHIR interface not be able to understand that a user who did not have an encounter during that period actually logged on? Why would we not know that? If we found that the percentage of use of these apps was going up, you would know that somebody used the app outside of the denominator, and I think you could capture that fairly easily, at least the number of accessed encounters that occurred for patients that did not have an encounter in the reporting period.

Jill Shuemaker

Fred just made a comment that we will know that they are in the numerator. Fred, would you like to elaborate on that?

Fredric Blavin





Hold on one second. I was just saying because we are separately collecting the numerator and denominator information, so, technically, the numerator would capture individuals with and without an encounter, and the denominator is just there to standardize the measure across different products and developers, so we would have that information captured in the actual numerator of the measure.

Jim Jirjis

So, if there was a metric that said percentage of logons to apps for patients... What percentage of all logins had patients who had an encounter during a certain timeframe versus not, because that might be an important insight for ONC that value-based care arrangements create substitution, and a measure like that would at least capture acceleration of app use outside of encounters.

Fredric Blavin

That is a good suggestion. I think we can incorporate that within the recommendations.

Bryant Thomas Karras

Is the denominator for traditional encounters and the numerator for online or app-based encounters?

Jim Jirjis

I am thinking the denominator is total number of app sessions and the numerator is percent done on patients who had at least one encounter versus not. The denominator would just split to total number of app sessions. The numerator is where we distinguish between the two.

Bryant Thomas Karras

This is Bryant. I just want to point out that from a public health standpoint, we have had... And, maybe our provider friends can comment on this. The denominators have been inflated by people seeking vaccine care with a provider that they do not normally work with because they had the vaccine. Do they become a permanent part of the denominator, or do they get phased out as they go back to their normal provider? I am curious if we are going to have skewed ratios.

Jim Jirjis

This is Jim Jirjis again. I think that is okay because if we just said for the reporting period how many app uses we had versus encounters, if I were ONC, I would want to know that it used to be 5 to 1 and now it is 10 app uses per encounter, now 11. You are right that there will be detail in what is driving it, but knowing that patients are increasingly using these apps, even outside of encounters, was valuable.

Jill Shuemaker

I am going to read that. Steve Waldren put this into the chat: "Since our reporting period is one a year, I would say today and in the near future, there would be an encounter for those using digital apps. In the future, this may not always be the case." And then, he says, "They would phase out for the next reporting period unless they have another encounter." Jim Jirjis says, "Steven, I agree, and I also think that true risk-shifting will encourage us to not have people have to come in for yearly encounters." So then, are we okay here? This is Bullet 2, "An active patient is one that has had an encounter within the reporting period."

Jim Jirjis





For that measure, yes. I am just suggesting an additional measure that gives us some insight into if people who have not had an encounter are using apps. That is all I am suggesting.

Jill Shuemaker

Okay, yeah. Let's make a note of that. And then, there are some recommendations that we are going to look at for the future, so let's see what is on that and see if we can add it here. Okay, let's go to the next slide. This is "Recommendations for patient access/use of third-party patient-facing apps," and again, this was pulled from our agreed-upon recommendations into the slide deck.

Steven Lane

It looks good.

Jill Shuemaker

Okay. All right, next slide. And again, we are still on patient access measure, and this is the measure "Collection of app privacy policy," and we recommended to remove this measure.

Steven Lane

What is the other mechanism by which ONC will determine if people are doing this?

Jill Shuemaker

Can anyone comment on that? I do not have that information.

Jim Jirjis

Can you repeat the question?

Steven Lane

My question was if we are removing... This measure seems, to me, to be about if EHRs, providers, or whatever are good at ensuring that apps actually have a privacy policy, and I am just wondering... I was delighted to see that because it seems like it is helping us get insight that people are actually doing some level of appropriate vetting, and if we are going to remove this measure, what other lever is going to give ONC that information?

Jim Jirjis

I am personally not aware of one. I can look into it.

Jill Shuemaker

Karen, can we maybe pull this section from the Google docs and see what note is there that might give some insight of how we reached this decision?

Steven Waldren

This is Waldren. If I remember, it was twofold. So, I was thinking about our complexity tokens, but more importantly, that [inaudible] [00:20:46] certified EHR text cannot hinder connection of these other applications underneath the information blocking unless there is a security risk to the individual EHR itself. The assumption was that not many EMRs are going to go out and seek out and make sure that they actually do have a policy, and if they do, it is going to be at a station by the app vendor itself, so, knowing what is in





there and the appropriateness of that would not be there as well, so it just seemed like that that is not an appropriate use of our complexity tokens, and that the other two measures inside this subcategory were much more important, therefore **[inaudible]**.

Jill Shuemaker

Thanks, Steve. That is helpful since we do not have that note on the Google doc, so Cassie, you can go back to the slide, and comments in the slide... Someone said, "There is nothing that currently exists," and then, Jim noted, "I would want to make sure there is a process. Maybe this is part of SAFER and/or should be addressed in SAFER."

Jim Jirjis

Hey, this is Jim. Just to comment real quickly there, we are aware... There is one record that is one of these apps, and they made us aware that Geisinger and a few other places had put in place an information-blocking, exception-driven checklist, and it was simple as "Does the app have a privacy policy? Does it even have...whatever?" And, that seemed like a safe usage of this, and it would not be violation of information blocking. In fact, it would be protected by... If someone does not have a privacy policy, that ought to be a worry for a provider that privacy or safety exceptions might not be in place. I am saying that to the "other levers" part, I am wondering if a tool like SAFER that is now required every year, where you are doing a self-assessment, whether provider...whether that is where we can say that the safe, responsible use of an EHR now also includes these apps, and if there is a process in making sure that those apps are vetted to the extent that the exceptions allow. That is all I meant. That may be alternative.

Jill Shuemaker

Thanks, Jim. All right, with that additional information, are we still okay with removing this measure so we can move forward, or do we need to...?

Steven Lane

[Inaudible – crosstalk] [00:23:33] with the sentiment that the reporting program is not the right place to do this.

Jill Shuemaker

All right, let's add that language, then. Thank you, Steve. I think that was you.

Steven Lane

Steven Lane.

Jill Shuemaker

Okay. Thank you, Steve. Jim just said, "I would have a comment that ONC deal with this in another manner, like SAFER." Okay, great. Thank you, Jim. Next slide. All right, so, we are moving on to the public health set of measures, and just as a reminder, there was a section that was under the topics of recommendations for further discussion. They are not in the slide deck right now because we are going to have a guest speaker, and then we will talk about those afterwards. So, these are just presenting what we agreed upon. And so, the slide deck, health information... Cassie, we are just going to stay on the slide deck, thanks. So, "Sending vaccine data to IIS." I will give you a chance to look through this.





Steven Lane

On the second bullet, I would just come up with a wording other than the use of the word “whose” because vaccine administration is not a “who.” It should be something more like “the information from which was.”

Jill Shuemaker

Thank you, good catch. All right, any comments? Can we move on to the next slide?

Bryant Thomas Karras

I had previously noted that not all registries are state-based. There would be territories and tribal registries. I thought I had made the comment.

Steven Lane

Yeah, that is what the third bullet is about.

Bryant Thomas Karras

But, it only says “state.”

Steven Lane

Sorry, it was on the prior slide.

Jill Shuemaker

Go back one slide, please.

Bryant Thomas Karras

I had made the change to reflect that it is not just states, and it looks like that did not...

Steven Lane

Do you see that bullet, Bryant? “Stratified by registry submitted to avoid the complexity of tending to stratify by state.” Does that capture it?

Bryant Thomas Karras

Well...the outcome is fine. It is just that the reasoning is that it is not just states.

Jill Shuemaker

Okay. Do you want to recommend...

Bryant Thomas Karras

I guess it does not matter. It does not change the outcome. I am just trying to make sure that... The explanation is not exactly correct, but the outcome is fine.

Jill Shuemaker

Okay. Do you want to recommend another way of wording it? We are happy to implement that or integrate it into the statement.

Bryant Thomas Karras





Maybe I will ask our AIRA friends if there is a better terminology when they are speaking rather than state “by jurisdiction” or...

Jill Shuemaker

We can certainly add that, “attempting to stratify by state or jurisdiction,” if that makes it clearer.

Mary Beth Kurilo

This is Mary Beth with AIRA, and I would agree with that, and I second what Bryant said that the outcome is fine, but just clarifying “not stratifying by state or jurisdiction” sounds a little bit more inclusive for those non-state IIS out there.

Jill Shuemaker

Great, thank you.

Mary Beth Kurilo

Thanks for that addition.

Jill Shuemaker

All right, next slide. All right, again, we are still on the public health information exchange, and this is “Querying of IIS by healthcare providers using EHRs.” All right. No comments here? All right, we will move on to the next slide. So now, we are moving on to the clinical care information exchange set of measures, and this is the measure “Viewing summary-of-care records.” And, there are two slides for this, actually three slides, so this is one of three slides that we will present on this topic.

Steven Lane

It is not a big deal, but you need a comma after the word “receive” in the top line there.

Jill Shuemaker

Grammar is a part of reviewing, so thank you for adding that.

Steven Lane

And here, again, this fourth bullet... I commented on that in the first couple of slides. Perhaps we should pull these two bullets together and move them to cross-cutting.

Jill Shuemaker

Is this a point that would be common across all measures, or just those two?

Steven Lane

I would suspect it would. You would have to think it through. It probably applies to the public health measures too. The issue is simply that some vendors have grown by acquisition, and they just have different products that do really different things.

Sheryl Turney

I am not sure it hurts to pull it up and have it cross-cutting.





Jill Shuemaker

Can you elaborate on that a little bit?

Sheryl Turney

Well, I was just speaking to the question of is it just specific to these two, or is it larger? I do not see why it would hurt to pull it up and have it be across everything. It would only be a good thing, if it can be done.

Jill Shuemaker

All right. Any other discussion around that? Anyone see that there is a measure that this would not be relevant to?

Steven Waldren

This is Waldren. I agree with moving it up, but could it start with “when possible” so that if it is not possible...

Jill Shuemaker

Okay. All right, let's add this to the cross-cutting recommendation. Next slide, please.

Steven Lane

Looks good.

Jill Shuemaker

All right. Next slide, please.

Steven Waldren

This is Waldren. Just in the first one there, where it talks about “parsed,” do we want to use the same language with [inaudible] [00:33:30]?

Steven Lane

I was going to say the same thing. We should use the terms from the prior slide, “parsed” and “integrated,” used separately. “Parsed,” comma, “integrated, and viewed separately.”

Jill Shuemaker

All right. We will add “integrated.” All right, any comments on the slide? All right, let's move on to the next slide. All right, this is for our clinical care information exchange, and this is the use of third-party clinician-facing apps.

Steven Lane

We used a different way of describing the same categorization levels in an earlier metric. I think we said less than 10, 10-plus, 100-plus. We should probably just express those similarly in the two recommendations. “Non-value-added variations,” something we do not like.

Jill Shuemaker

All right. Any other comments on this slide? All right, let's move on to the next one. This is still in data quality and completeness, and this is “By data element, percentage of data complete.” All right, is everybody good with this?





Bryant Thomas Karras

Do we need to specify types of phone numbers, I wonder? Identify that in the last five to 10 years, it is not just a single phone number that needs to be collected for a person, but there needs to be a stratification for cell or mobile.

Steven Lane

I feel like that goes without saying when we say “phone numbers,” plural, but we could certainly add a parenthetical statement.

Bryant Thomas Karras

The completeness of this could be 100% because people have their home phone number, work phone number, and cell phone, which is the most critical for identification of demographics, and it might not be collected.

Steven Waldren

This is Waldren. I think that goes to Point 2. An individual data element is not all that meaningful. What is it for? We talked there about if it is about patient matching, it should mention that that mobile number is the most important.

Bryant Thomas Karras

Maybe we specifically call out in Sub-Bullet 3 “especially mobile number,” and I do not think it should be a future prioritization. I think it should be prioritized now. We have research evidence to show that it is the most useful thing for identifying an individual.

Jill Shuemaker

All right. Is everyone in agreement with adding mobile, work, or home numbers?

Steven Lane

Sounds good.

Jill Shuemaker

And, Vishali just said that data elements such as mother’s maiden name were deemed relevant for patient matching, and also for health equity. Thank you, Vishali.

Steven Lane

“Mother’s maiden name” sounds like such a quaint concept these days.

Bryant Thomas Karras

Again, when our guest speakers come on, they may be able to shed some light on the importance of maiden names in identifying children receiving vaccines.

Jill Shuemaker

Thank you. And, Vishali said it is used for patient-matching and identification-related purposes.





Abby Sears

Just a couple of comments on this. I recognize that what I am going to say is going to... I do not have a solution to it, but just from that context...for some level of the population, phone numbers are shared numbers and/or burner phones, and that patient population is the patient population that is actually two to three times more likely to be COVID, whether it is COVID or almost anything, to be honest with you. So, I do not know that we should not do it, so I am bringing this up from a place of not being sure that I would change the recommendation. I am trying to process that, but I also just would like to acknowledge that phone numbers are not a very good use of connecting back to the patient population that is most at risk. They share phones and they use burner phones, so I just wanted you to know that, but nonetheless, it is still probably a very good thing to do.

Jill Shuemaker

Great. Thank you for that additional context. All right, let's move to the next slide, please. And, these are other considerations regarding the "Interpretation for data quality and completeness" measure.

Abby Sears

I am just going to say another thing. A lot of the data matching issues that we are experiencing, at least from our standpoint, come from the lab, not from the provider. This continues to put more burden on the providers when they have plenty of information that when it comes back from the lab, it is not complete, so that is just an observation, and I am not sure [inaudible] [00:43:51]. It is something to think about.

Jill Shuemaker

All right. Is there a recommendation, change, update, or something in the wording that we need to clarify there?

Abby Sears

I do not know. I am thinking.

Jill Shuemaker

Okay, thanks Abby.

Abby Sears

Again, I do not think I can disagree that this is a good idea. I think maybe in my mind, it is more that there is an "and." I am not seeing the "and." And, the way this is framed, it suggests that the provider system will be able to solve the majority of these issues, and frankly, that is not true.

Bryant Thomas Karras

This is Bryant. So, I made the last dot point there where I am having conversations with the conformance group and with the public health group at HL7 workgroup to figure out if there is some type of emphasis on required-if-exists or RE. That could lead to more complete data collection, and the challenge is that in EHR provider-facing systems, if something is not truly required, then it may not be collected, and systems tend to treat RE as optional in their guidance to the data collectors.

So, what happens is when you only... So, the cell phone is an example. Not everybody has a cell phone, so it is designated as RE, and if they have it, you have to report it, but since the data collection device, the





end-user interface that is collecting the data from the patient, is not truly required, they do not ask for the cell phone number, and then it does not get sent to the lab, and then it does not get sent to public health for follow-up. So, we need some better way to communicate to and instruct the end user, who may be a front-desk person or who may be a volunteer who might not understand the upstream implications of not collecting certain data. So, I appreciate that the labs may strip out some elements, but there is also a true data collection problem that is happening at the provider level.

Abby Sears

Sometimes it is not that they are not capturing it, sometimes it is that they do not have them, kind of like I was just saying. So, there is a large portion of the population that uses burners.

Bryant Thomas Karras

Yes, but that burner is still a phone and should be collected because in that moment in time, it is the way to contact that person, and over 80% of the population has cell phones, and we are only getting them for 40-50% of data collected, so there is a gap.

Jill Shuemaker

But, do you feel like we have captured it there? On that last bullet, we are making a statement that there are ramifications to that. So, are you saying that there needs to be additional clarity there? It does sound like we are making a clear comment.

Bryant Thomas Karras

Yeah. I just was trying to explain to people who are...

Jill Shuemaker

Oh, okay.

Bryant Thomas Karras

Ideally, I would like there to be a stronger recommendation, but at the moment, there is no way to represent that in the standards.

Jill Shuemaker

Okay, yeah.

Abby Sears

Is it that the front desk is... Yeah, that is just a larger issue. I am just going to tell you that requiring it or not is not going to change the outcome there, but I do not know if I agree too... I do not know that there is a better solution. I am just not sure that this will solve the issue, but why not try, I guess?

Jill Shuemaker

Yeah. And, Jim was just cross-checking about the burner phone, and I think we concluded that it does help because at that moment in time, at least they have that phone number. I think Bryant said that it does help. All right. Let's go to the next slide.

Abby Sears





The only other thing I would say is I agree with everything there. The one thing that I do not see anything about is requiring the labs to process the information that we do send to them. Again, I think what I am concerned about is the continued reinforcement at the provider level but not the reinforcement at the lab level.

Jill Shuemaker

All right, can we go back one slide? I know we are at time and we need to move on to the speaker. So, are you recommending adding language there to point out the lab on that?

Abby Sears

Yeah, the same accountability for the lab that you are expecting from the providers.

Jill Shuemaker

And, are you recommending adding that to an existing bullet, or is that a separate bullet?

Abby Sears

I would leave that to Bryant since that is his comment. I do not want to... Here is what I would say. I think there needs to be an equal bullet that is as accountable to the lab systems as it is to the provider systems because I think we will get a better outcome.

Jim Jirjis

Hey, this is Jim Jirjis. Just to boost both of those, in public health reporting, I can tell you that we at HCA interact with 225 different labs. None of them use, for example, LOINC standards or adhere to completeness and data quality, and so it ends up driving an enormous burden on the provider to recover from that.

Abby Sears

Yeah, but public health cannot... And, I do not think ONC certifies Laboratory Information Management systems, so the only way to enforce completeness is to have the providers or the health systems that are subcontracting with the labs have those labs adhere to those standards, so...

Jim Jirjis

Yeah, I know that in some discussions we have had with the legislative side, they were going over whether there are levers, such as CLIA, to approach it from the lab side, but you are right, it has to be the users demanding it.

Jill Shuemaker

Yeah, okay. I know we are having a robust discussion, but we really have to move on to make sure that we give our speaker enough time to talk about public health. So, maybe this discussion could continue into that discussion if it is related, but let's go ahead and give her an opportunity to share. So, Mary Beth and Eric, I am going to turn it over to you, and Bryant, if you would like to do an introduction, you are more than welcome to do that.

Recommendations for Public Health Information Exchange Measures (00:52:26)

Bryant Thomas Karras





It is my pleasure to introduce my colleagues, Mary Beth and Eric, who have been working incredibly diligently over the past many years, and I think immunization registries across the country are a success story in measurement and improvements that can occur when one systematically examines and measures what is going on. So, to a certain extent, what you are about to hear from Mary Beth and Eric should be encouraging to our group that putting a spotlight on activities leads to improvement. So, without further ado, I will let Mary Beth and Eric take over.

Mary Beth Kurilo

Thanks so much, Bryant, and thank you to everybody on the task force for letting us weigh in about these EHR reporting measures. We really appreciate the time and the opportunity to collaborate on this. Before I get into ACK messages, I did want to weigh in on the previous demographics discussion because for mother's maiden name, which Bryant shared as well, it is used heavily for matching for child immunization records, and it is one of the few persistent identifiers for children. Address, phone, and even last name might change over time, so those data-persistent identifiers like mother's maiden name can really help in matching and de-duplicating records across immunization registries.

And then, for phone number, I do understand that the number may change because of burner phones, and there are absolutely equity issues that need to be considered there, but it is also used as another factor for identifying individuals who need access to their own immunization record or vaccine credentials through a consumer-facing app, so I think it is only going to grow in importance as we move forward. So, I just wanted to get those two pieces on the records.

And then, to come back to acknowledgements and this whole idea of how we determine the success of a submission method, this is an area where IIS has spent a lot of time and put in enormous work to provide clear communication back to our partners to ensure that that exchange is meaningful, and the analogy that we are fond of using across the IIS community is that it is similar to hotel reservations. If you make a reservation online, you can expect a confirmation that comes back that says, "Yes, your reservation is confirmed, here is your confirmation number," or "No, your Visa did not go through, so you need to resubmit," and IIS operates the same way.

And, in the absence of IIS sending back this ACK or confirmation message, or in the EHR, actually reading that information back, we really do not know the outcome, and that leaves a lot of room for poor data quality to creep in. So, what we are interested in is creating an EHR reporting measure that really is as meaningful as possible and can give a true read on what is going on there.

So, to move to the next slide, I want to just share a little bit about one of our significant strategies for improving acknowledgement messages, and that is our measurement and improvement initiative, and it is a CDC-sponsored effort where AIRA links with preproduction instances of IIS systems and objectively tests IIS for their alignment with standards. This process is voluntary, but we have over 92% of IIS participating with us, and they are being measured at least quarterly, and we can literally track improvements by IIS and then provide additional technical assistance to those IIS who need some added support to really come into alignment.

And, we have seen amazing process across all of our content areas, such as query, submission, clinical decision support forecasting, but we have seen significant improvement around ACKs, and given the





importance of acknowledgement messages, this is where AIRA and most of the IIS community have really been zeroing in and focusing for the last several years. So, with that, I will hand it over to Eric Larson, who is our technical lead, who will share a little bit about the data that we are seeing and the improvement that we have seen recently. So, over to you, Eric.

Eric Larson

Thanks, Mary Beth, and Bryant too, as well as everyone else. It is a pleasure to be here. You can move to the next slide. What I really want to do is zero in on that acknowledgement message, or as Mary Beth nicely alluded to, the confirmation message on your hotel reservation. So, when we began our measurement improvement initiative, since we are all immunization experts, we all had access to the immunization registry, but when we began our work as testing, we now, in essence, emulated an EHR, though probably very poorly, in that we would send messages to the IIS, and then we would have to determine if they accepted the message or rejected the message, and we drew a line very clearly on “accepted” or “rejected.”

And, when we started back in 2016, at that point in time, we were able to measure 23 IIS, but what we ran into was that it took us a lot of work. There were 11 different ways that we came up with in understanding the IIS’s acknowledgement message about whether they accepted or rejected the message, and it was very untenable. It was eye-opening for us to realize that everyone was following the standard, yet doing things a little bit differently about what it means to be accepted versus rejected on an HL7 message. So, it was a call to action for us to get IIS to work towards a unified approach in that yes, the HL7 standard is in place, but as we all know, there are areas of wiggle room in that, and that is what leads to what we were calling flavors of acknowledgement messages.

If we go to the next slide, what we did as a community with the AIRA standards workgroup is develop further guidance on that HL7 message, which was deemed an acknowledgement guidance document, and we used that guidance document to align all of the IIS, and we were really thoughtful about how we wanted to communicate the acknowledgement message. We talked about how it was not important for us to tell EHRs what we thought about their message, but more what we wanted the acknowledgement message to be actionable for EHRs, pharmacies, and clinicians, so we tried to get to the point of “What action do I have to take based on this message that I received as an EHR? Do I have to resubmit it? Was it accepted? Was it rejected?” Those were the levels, and the goal was to get to one standardized ACK message and the meanings of those key fields for the IIS.

To go to the next slide, we can see the tremendous progress that we have been making in this. So, in 2016, we were able to measure 23 IIS with 11 different flavors. Had we brought on more IIS at that point in time, we would have had to write more ACK processors, if you will, which is what we called them to understand the different IISes and their flavors, but we really pushed the community toward one acknowledgement message. Today, we have 53 IIS, and we are using one single acknowledgement message, understanding how we want to accept or reject a message, so we have made great progress.

I think one thing that we really had to be careful with when we did this, which is why maybe a lot of people are not even aware of this until we get in front of groups and show some of the data, is that we could not break existing interfaces. At the end of 2019, pre-pandemic, there were 117,000 live interfaces across the U.S. Obviously, when you upgrade an IIS, you have to be careful to make sure you are still backwards compatible to any of the existing interfaces and not break any of those. So, some of this information might





be new to a lot of people that all this work has been done and they can update their interface and read these ACKs very consistently across all of the IIS. Next slide, please.

So, that was for our testing program, but this is actually being used in production today. There is a workgroup that I do not know how many folks know about, the HIMMS/AIRA IIT Project, which is the immunization integration project, and working with those EHR vendor-focused folks, providers, and IIS to improve many different things. One of the ones that we most recently worked on was the ACK Improvement Project to improve data quality. So, after going through the project and learning what IIS had done, learning what is capable in an EHR, and learning where a provider may want to work on some things, the Tennessee Department of Health, Vanderbilt University, and Epic worked together to pilot a project to see if they could use all of this information to improve acknowledgement messages.

I think there is a link that may be hiding a little bit on the bottom, and I think it went from white to black in our transition of slides, but there is a link for people who want more information, a nice webinar on it, and how they were able to improve data quality in the IIS through looking at the ACKs, and primarily, they were focused on those rejections of records. How many records did they send to the IIS that the IIS did not accept? As we all know, it is a two-way street, so they actually found really cool information that the IIS can improve upon and really great information that the EHR can improve upon, as well as provider capture on how to improve that. So, they are continuing to do that pilot project. I think they are now actually working on it on an every-Monday basis. They look at the rejection rates and improve them, so there are very tangible things that are in process and working. Next slide.

I wanted to finally zero in on successful messages, and from what I have been hearing, though I have not been able to listen to all the conversations, how do we identify a successful message for this numerator? Inside the ACK guidance document that I talked about, there are some WEDIs in there if you are at the HL7 WEDI level. It is a really short document if people want to give it a read, only five or six pages. It more or less says that you have no errors in your acknowledgement or your confirmation message back with a severity of "E." There are different severities of error: Informational, warning, and error, "E" being the most severe of error.

So, in HL7 speak, which is something you might want to put in the measure, a message is considered successful if either of the following are true: There are zero ERR segments, meaning in other words that there are no errors at all and it is an absolutely pristine message, or there are ERR segments that exist, but none of them contain the code of E in ERR4, which is the severity code. In other words, you are saying the IIS has been able to accept this data. It may warn you about some data quality issues, like a false phone number or some missing data that they really like, but you did not provide, but all in all, they were able to accept it.

So, it is really pretty straightforward from a consumption standpoint that you are looking for essentially one letter in the acknowledgement message to say, "Okay, something went wrong here and we need to resubmit this message," and I think with that, the next slide is really the last slide, and it is just some selected resources that I pulled together for today if anybody is interested in reading it. Mary Beth, I promised to turn it back over to you to see if there is anything I may have been ambiguous about or that you needed to clean up as I was going through my slides to add some more clarity, so I will turn it back to you, and then I think we can open it up.





Mary Beth Kurilo

Great. Thank you, Eric. I think the only piece that I will drive home, because I know that one of the comments in the documents that are being shared was that some IIS do not send back acknowledgement messages, and we do have a small handful of IIS who have not implemented ACKs yet. Hopefully they will by the time the EHR measures go into effect. We would like to have 100% of IIS acting consistently on that. But, if the IIS does not send back an ACK, either because they have not implemented them or because there is a connection issue, they just do not count. They just would not be subtracted from that numerator.

And so, I think from the EHR perspective, the issue is that the IIS is not sending them back. That really would not affect the measure because there just would not be anything to take out of that set of successful measures. So, that is the only other piece that I will drive home, but I think you have covered a lot of those details, Eric, so I will just defer to Bryant to see if there is anything that he wants to add.

Jill Shuemaker

This Jill. I just want to step in here. We have about 10 minutes, and I wanted Cassie to pull up from our Google docs the section that Bryant had suggested for further discussion. And so, thank you, Mary Beth and Eric, for giving us that additional information and helping us understand the technology a little bit better. And so, I want to just begin... These are points that were around this topic that we were not able to move into the recommendations, and so, I want to open it up to the group to give feedback, now that we have maybe a better understand of how these interact in the EHR, if there is agreement or if there is anything we want to bring forward and add to our recommendations around the public health measures.

And, I will start by just reading some of the comments. Okay, Vishali said, "Very helpful, thanks for the presentation." Steven Lane said, "What levers exist to incentivize/require IIS to manage these messages in a consistent manner?" And, he went on to say, "Is there a role for [inaudible] [01:06:00] to help [inaudible] here through some sort of IIS certification, perhaps as a component of a more comprehensive public health IIS certification program?"

Bryant Thomas Karras

This is Bryant. I think one thing that...a takeaway that I would hope that people have is that Roman numeral III, "Not all registries send acknowledgements," is a minority, and maybe Eric can give us an approximate number of registries that do not send acknowledgement messages, and it might be less than 10%.

Eric Larson

Bryant, I do not know if I have an exact number on that, but yeah, that would be our suspicion. Sometimes it is not always as easy as just the IIS with the HIE potentially being in the middle, so sometimes there are some challenges there where, depending on how you connect to the IIS, you might get a different outcome in some jurisdictions where you may or may not connect to the HIE, and it is not all of the HIEs. There are plenty that pass it back.

Jill Shuemaker

I just want to keep up with the chat here. Abby said she agrees with Steven around the certification, and Mary Beth added, "The measurement and improvement [inaudible] [01:07:38] really functioned as a validation process, similar to certification. Now that IIS have more resources, they will be able to move more





quickly in implementing changes in response to the findings of M&I,” and Steve says, “An HIE in the middle is not an excuse.” Oh, it keeps going. Mary Beth says, “CDC is also folding this into their requirements,” and Steven Lane says, “HIEs need to provide consistent services.” We do not have a lot of time. We have about six minutes to wrap this section up, so, go ahead.

Mary Beth Kurilo

This is Mary Beth again. I was just going to add something around HIEs. There is a project funded by ONC that is looking at strengthening collaboration between IIS and the HIEs, and I know there is an issue around ACKs and HIEs needing to also play a standardized role with passing the ACKs through that came up at the [inaudible] [01:08:40] meeting last week, and so, I know it is on HIEs’ radar screen that they have an important role to play in terms of standardization here. So, I think that ONC project will really help us align standards on all sides on HIEs and IIS to really make sure we are in sync with our EHR partners as well.

Bryant Thomas Karras

Before we run out of time, can you scroll up a little bit to the agreed-upon? I think what those further considerations were trying to address is a suggestion that we had, which I am now not seeing here, of making the numerator be the number of successfully sent immunization reports, which would be the number that was sent minus the number of fatal errors that came back, and as Eric represented, there is now a clear and consistent message that comes back from IISes with that fatal error ACK, and we had put that recommendation into the previous draft, and I think it got held into these recommendations for further consideration. I am hoping that we can... Now that folks understand that there is consistency, maybe it could be elevated to be an agreed-upon recommendation.

Jill Shuemaker

Yeah, I think one of the reasons why it did not make it into the full agreed-upon recommendation was that not all systems have implemented the HL7 that is needed. So, I think the timeline for that... How quickly are these measures going to be required against the timeline for implementing HL7? So, I will open that up to the group for feedback.

Bryant Thomas Karras

But, I think the implementation of these HL7 messages has occurred. These are 2-5-1 messages.

Mary Beth Kurilo

Yeah, and I just wanted to verify if you are talking about implementation on the EHR side or implementation on the IIS side because I agree with Bryant. On the IIS side, I think HL7 is well implemented universally across IIS.

Jill Shuemaker

Yeah, these measures would be for certification for EHRs and other systems that require the certification, so they would need to be able to accept that HL7.

Bryant Thomas Karras

And, it is part of the NIST certification that these 2-5-1 messages are capable of being transmitted to immunization registries.





Sasha TerMaat

This is Sasha. I think we had a couple of different reservations that we were going to come back to. One was the challenge of measuring using ACK messages if that is not universally sent by the IIS, and therefore does not necessarily reflect about the EHR, so when we interpret the measures, we would have to understand how that worked, and I think we have heard two mitigations for that, one being if the measure were just removing fatal error acknowledgement, then it does not get affected if an IIS does not send an acknowledgement at all, and the other mitigation would be the increased adoption of the IIS sending of the acknowledgement.

I think another concern we had with this was just the overall question of where to spend complexity tokens. If we add to the complexity of measuring messages sent, an additional scan overall of the acknowledgements to remove some, or even more complicatedly, to associate each of those with the messages in the reporting, we just have to prioritize as a group that that is where the complexity tokens should be spent to be judicious with the processing we expect from each of the health systems' hardware. And so, I think the recommendation is actually I, on the next page, that we seem to be debating, so we would keep the second bullet in the agreed-upon recommendations and then move up the definition that is proposed in Bullet 1.I under "further discussion," if I am understanding correctly, and I know I missed some of the earlier material in this call and I apologize, but that is my impression here.

Jill Shuemaker

Sasha, could you say that again now that we have it up on the screen? Which ones?

Sasha TerMaat

Yeah. So, my sense is that if we feel that the risk of misinterpretation of the data is sufficiently mitigated by what we have learned and we feel like this is where we want to spend our complexity tokens across all the measures, then we would promote Bullet 1.I that we would define successful messages as total messages submitted minus acknowledgements with fatal errors into the agreed-upon recommendation.

Bryant Thomas Karras

I agree with that proposal. This is Bryant.

Jill Shuemaker

Okay. Anyone else? Is there anyone that does not agree with moving that up to recommendations? All right, let's move up I.

Eric Larson

One minor geeky nuance. The word "fatal error" may need to be better spelt out. As you move newer into different HL7 V.2 standards beyond 2-5-1, there is actually a concept of a fatal error, which may lead to some confusion for implementers in that nuance, so I am happy to work with the committee offline on how to maybe word that.

Bryant Thomas Karras

Yeah, do not use the word "fatal," but "error" for now.

Eric Larson





Yeah, just something... Yeah, exactly, just so we do not mislead what it is we are referring to.

Sasha TerMaat

I think “error” is too broad, actually. I think we need to be more specific. Did you not say that there are only certain error messages that would need to be removed?

Eric Larson

Yeah, exactly, it would be those, and I do not know how else to describe it, other than those that have a severity of E, which, unfortunately, HL7 definition defines as the word “error,” so I think they just reuse the word “error” too much, but that is how we... In our guidance document, we were just very clear about when we casually used the word “error” versus when we were specifically talking about the severity of the error, which was called “E.”

Bryant Thomas Karras

So, if we use the word “errors” and then put a parenthesis, 2-5-1, comma, capital E, does that...?

Eric Larson

Yeah, and I would even... I do not know how specific you want to be in your recommendations or how specific you need to be, so forgive me if I am too deep here, but I would even say “2-5-1, a severity level of E” or something like that so it is a little bit tighter link there, but again, I may be too far in.

Sasha TerMaat

Thinking about programming these, I actually think... And, this is not specific to public health measures, but in general, the type of bullet points that we have here are likely too ambiguous to actually program off of later, so maybe an overarching recommendation would be that these then be transformed into actual specifications, more akin to the type of specifications we use for other reporting measures, for consistent reporting implementation.

Eric Larson

I am not on the committee, but I agree 100%. I am coming from the techy world, too, so any consistency is helpful.

Bryant Thomas Karras

Thanks, Eric.

Jill Shuemaker

Do we agree that what we have now is adequate for this document?

Steven Lane

It is a step forward.

Jill Shuemaker

Okay. We have two minutes before we have to go to public comment. One page down, Cassie. Are there other bullet points that anyone feels like we can bring up to agreed-upon?





Bryant Thomas Karras

If we have one more minute, I am just curious if Eric or Mary Beth have any awareness of the CPT versus SNOMED inpatient and outpatient. That seems like something that is a bit of a challenge, and I am not sure how that is going to be addressed quickly in time for us to get these finalized.

Jill Shuemaker

Yeah, and Bryant, unfortunately, we do not have enough time to dig into that right now. We need to go to public comment. So, ONC, we are ready for public comment.

Public Comment (01:19:36)

Michael Berry

All right, thank you, Jill. Operator, can we open the line for public comments?

Operator

Yes. If you would like to make a public 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 comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing *.

Michael Berry

All right. While we are waiting to see if we have any public comments, I just want to remind everybody that we are back to our normal day to meet next week, which is Thursday, September 2nd, at 10:00 Eastern time, so I hope to see you all then. Operator, do we have any public comments?

Operator

No public comments at this time.

Michael Berry

All right, thank you. Jill?

Jill Shuemaker

All right. Thank you, Mike. So, we have nine minutes. I do want to let everyone know that we have not gotten to the standards adoption and conformance measures. Ken and Jim are meeting to bring some recommendations forward and clean up that section a little bit more. So, Ken and Jim, if you are able to complete that, if you are able to meet and have that in the Google docs probably by Friday with some recommendations, and then, if the task force could be sure to look at that before we meet next Thursday. And, just a reminder: Next Thursday is our last meeting to sign off on the slide deck before we turn it over to HITAC, so it will be really important for us to reach consensus and agreement on what we are going to include in the slide deck as our recommendations or not. So, I just want to ask right now if there are any questions or comments around that.

Bryant Thomas Karras

Could you say the numeric day rather than “next Friday” so it is clear?

Jill Shuemaker





It is next Thursday, and correct me if I am wrong, ONC, it looks like September 2nd.

Bryant Thomas Karras

Okay. I just want to make sure you do not mean “next” as in “tomorrow.”

Jill Shuemaker

No, we will not be meeting tomorrow. So, September 2nd.

Bryant Thomas Karras

Thank you.

Jill Shuemaker

Any other comments or additions, anyone? I am happy to let you go early, but I want to make sure that we have given this slide deck that we have right now thorough view, and if anyone has a comment about bringing up any of the final public health pieces, we do have a couple minutes that we can discuss that.

Bryant Thomas Karras

This is Bryant. One comment I had in the document that I am not sure made it onto the slides was a suggestion that everything else being the same, if that time period of July 1 to June 30 be used across all measures, then that would eliminate any seasonal variation in vaccine utilization. Did that survive the final draft?

Jill Shuemaker

Yeah, I do remember seeing that, and I thought we had moved that over, but let’s just take a look at that.

Bryant Thomas Karras

We had moved it over, and then it looks like it got pulled into an overarching and may have gotten lost.

Jill Shuemaker

Yeah. Vishali said it ended up in cross-cutting.

Bryant Thomas Karras

So, we still need to get that so it does not get lost.

Jill Shuemaker

Okay, we can add that to the public health section of that recommended [inaudible – crosstalk] [01:24:00] period.

Bryant Thomas Karras

Yeah, or it can be in cross-cutting, it just needs to say that it is a standard... I think part of the reason for the vendor getting to pick the time period is because of implementation time test, which I totally understand, but once there is a stable version, it might behoove us to use a time period that is consistent across the country.

Jill Shuemaker





Agreed.

Sasha TerMaat

We do have a consistent, agreed-upon recommendation, though, that says it should use the same annual reporting period as the other measures.

Bryant Thomas Karras

Right, but the recommendation of July 1 to June 30th as a default got lost.

Sasha TerMaat

I just want to clarify that it is not variable in the recommendation we agreed upon.

Jill Shuemaker

Next slide, please. Let's just look at the public health. Can we go to the next slide, please? Oh, it is the public health measures.

Bryant Thomas Karras

We had had a previously agreed-upon public health measure that got moved to cross-cutting, and when it got moved to cross-cutting, it got diluted.

Jill Shuemaker

Okay. We can certainly make a note...

Bryant Thomas Karras

Ah, there it is. "Use July 1 to June 30th as the default 12-month reporting period." So, that is there, but is it okay that there is no explanation that that is because of preferred seasonality effects...? The outcome is fine, as long as... Do we need to communicate the rationale? If not, then we are good.

Jill Shuemaker

Yeah, I think we agree that this would be cross-cutting for all measures, so it did not matter in any one particular set of measures: Public health, patient access, or the others.

Bryant Thomas Karras

Yeah. This just goes back to the same thing as required versus optional. If this gets communicated as an optionality to use July 1 and if the importance of the consistency is not communicated to the EHR vendors, it may not be implemented as such.

Jill Shuemaker

Okay. So, I recommend we add a note under the public health that the July 1 to June 30 reporting period will need to be implemented particularly for the public health measures. All right, thank you all for your time today, and again, thank you for meeting us on a Wednesday. Enjoy the rest of your week, and we look forward to wrapping this slide deck up next Thursday. So, have a great day.

Adjourn (01:27:53)

