**Interoperability Report Feedback from SSM Health**

March 27, 2015

New Article : Federal Health IT Coordinator Sets 2017 Interoperability Goal

<http://www.modernhealthcare.com/article/20150130/NEWS/301309955?utm_source=modernhealthcare&utm_medium=email&utm_content=20150130-NEWS-301309955&utm_campaign=mh-alert>

The full document:

<http://www.healthit.gov/sites/default/files/nationwide-interoperability-roadmap-draft-version-1.0.pdf>

1. General
   1. Are the actions proposed in the draft interoperability Roadmap the right actions to improve interoperability nationwide in the near term while working toward a learning health system in the long term?
   2. What, if any, gaps need to be addressed?
   3. Is the timing of specific actions appropriate?
   4. Are the right actors/stakeholders associated with critical actions?

* *Governance – Responsibility for governing interoperability and the standards by which is it is measured should be made up of a group of representatives from both the government and the industry including Health Care Organizations of both providers and hospital systems, as well as payers and public health representatives. Representatives should include physicians, hospitals/acute-care, post-acute care, consumers, EMS professionals, government agencies, public health, pharmacies, home care, government agencies, research, etc… Governance should not be solely the responsibility of ONC as it is the users of the data that will determine what the gaps are and what the real need is order to make interoperability valuable to health care professionals, patients, and payers.*
* *Common Clinical Data Set – A common clinical data set must not only be a ‘list’ of what is required but also must define how that clinical data set is discretely shared and where every element is uniquely identified per patient. Discretely identifying every element of the clinical data set unique to each patient allows systems/EHRs to track these items and present the information to clinicians so that they can take action on the elements discretely in their chart. It will prevent the issues we see today where discrete elements are sent to us but they are not uniquely identified and thus subsequent queries continue to pull those same discrete data elements which increases clutter, workflow burden and information overload on the end user. This encourages users to avoid looking at the outside data b/c they see it has duplicative and not value added.*
* *Enhance Incentives – We recommend less focus on incentives by ONC and more on requirements to certify. Payers and other industry members can help to identify incentives if needed but they shouldn’t drive health care organizations to participate in specific Health Information Exchanges. For example, we must participate in a specific HIE in order to continue receiving reimbursement from a particular payer. Instead of specifying which HIEs an organization must participate in (and pay fees to), the interoperability road map should create uniform standards of exchange so that all stakeholders can obtain the same value from any exchange mechanism.*
* *Privacy and Security – An area where ONC can really help to move information exchange forward is in creating a standardized approach to the consent model requirements for Health Information Exchange. We recommend that ONC /the Road Map make a stronger comment on the statement that HIPAA allows for the exchange of clinical data and should not be a limiting factor for health care organizations or their vendors to exchange PHI. Unify a SINGLE model for consent – is consent required or NOT? States should not be allowed to have different consent models (opt-in, opt-out), different lengths of time for valid consents, etc… State specific standards and even organization’s interpretations of their own state laws have created unnecessary barriers to Health Information Exchange. Creating a single approach to protecting health information privacy is critical to protecting our patients/populations as well as leveraging data exchange to promote the flow of information to provide the best quality care. There must be a balance between these two needs and creating a single streamlined definition is necessary in order to establish this balance. Current inconsistencies create confusion and questions in the mind of users…”am I seeing everything I need to see”?*

1. Priority Use Cases
   1. Appendix H lists the priority use cases submitted to ONC through public comment, listening sessions, and federal agency discussions. The list is too lengthy and needs further prioritization. Please submit 3 priority use cases from this list that should inform priorities for the development of technical standards, policies and implementation specifications.

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| 12 | Providers are able to access x-rays and other images in addition to the reports on patients they are treating, regardless of where the films were taken or housed. (6 votes) |
| 41 | Providers and patients receive electronic laboratory results from laboratory information systems (LISs) inside and outside their organization (6 votes) |
| 5 | Population health measurement is supported at the community level and includes data from all relevant sources on each patient in the population and is accessible to providers and other stakeholders focused on improving health. (4 Votes) |
| 9 | Providers should be alerted or have access to notifications that their attributed patients have had an ER visit, or an admission to or discharge from a hospital. (4 Votes) |

1. Governance
   1. The draft interoperability roadmap includes a call to action for health IT stakeholders to come together to establish a coordinated governance process for nationwide interoperability. ONC would like to recognize and support this process once it is established. How can ONC best recognize and support the industry-led governance effort?

*Responsibility for governing interoperability and the standards by which is it is measured should be made up of a group of representatives from both the government and the industry including Health Care Organizations of both providers and hospital systems, as well as payers and public health representatives. Representatives should include physicians, hospitals/acute-care, post-acute care, consumers, EMS professionals, government agencies, public health, pharmacies, home care, government agencies, research, etc… Governance should not be solely the responsibility of ONC as it is the users of the data that will determine what the gaps are and what the real need is order to make interoperability valuable to health care professionals, patients, and payers.*

*Specific questions:*

* + 1. *The governing body should include mechanisms to answer questions about the standards and how to interpret the standards.*
    2. *The governing body should be able to enforce adherence to the standards.*
    3. *The governing body should be able to define rules surrounding the technical standards and a single best standard that ALL EHRs will be required to use.*

*If the governance body cannot agree on a topic, ONC should provide the guidance and decision making authority to keep the project / issues moving forward. They should monitor these process so that issues do not create a bureaucracy that bog down development and progress. The governance group must include informed organizations who have shown forward movement to establishing interoperability from both the vendor and healthcare organization side of the world. Recommend that medical informatics directors and nursing informatics directors are the types of people who are involved so that the design and governance is focused on real-world operational workflows, population health and value. Technical leaders from vendor and healthcare organizations should be represented in both governance and design so that implementation of standards is seamless across the different technologies and does not require a large degree of technical effort and maintenance.*

1. Supportive Business, Cultural, Clinical and Regulatory
   1. How can private health plans and purchasers support providers to send, find or receive common clinical data across the care continuum through financial incentives? Should they align with federal policies that reinforce adoption of standards and certification?

*This should not be a separate incentive program from MU. We need MU to adopt Interoperability as part of that program so that we are all working toward one goal and that the programs do not publish conflicting requirements. There are many organizations that have already created policies and standards. We should leverage the lessons and products from these working groups to help move us forward instead of constructing a new group and starting over.*

*This group should govern payer involvement and access to particular pieces of information so again there is not a volley for what each payer wants. A standard library of reports/analytics should be developed to allow health plans to access data and benchmark organizations. ONC should focus on the standards, coordination, and governance of the sharing of data and the ‘rules’ by which health plans can access the information but should not comment on or drive whether or not health plans incentivize providers to participate. Perhaps it should be the opposite in which payers should not be allowed to dictate or withhold reimbursement from Health Care Organizations if they do not participate in prescribed HIEs. Perhaps linking reimbursement to participation in the National HIE but not all the individual/local ones would be a way to reduce cost, reduce variation, and further support standardization.*

*The focus must be on the usability of the information. Simply forcing organizations to share data is not enough. How that information is presented to the clinician is vital to adoption. We must focus on driving adoption and not through means of incentive or penalty but more focus on the value the data provides. EHRs need to focus on making the information useable without creating onerous workflows to incorporate the discrete data into the chart. The data must be accurate, require minimal review or action on the part of the user to incorporate it into the receiving organization’s EHR so that it can be utilities and trusted. Once that data is utilized and trusted it will then provide value to the clinician and to caring for populations.*

1. Privacy and Security Protections for Health Information
   1. What security aspects of RESTful services need to be addressed in a standardized manner?

*Need to establish systematic ways to audit and requirements that auditable information be included in the implementation of RESTful web services. How is the audit information of which organization is performing the query included in the request for information? The theme in many of these categories is the development of standards. Standards are needed so that EHR developers and end users alike can create workflows and processes around trusted expectations for the data they are receiving.*

1. Core Technical Standards and Functions
   1. Which data elements in the proposed common clinical data set list need to be further standardized? And in what way?
   2. Do you believe the approach proposed for Accurate Individual Data Matching will sufficiently address the industry needs and address current barriers?

*Again there must be standards. Standard data set, standard methods for sharing, standard consent modeling, standards for patient identification, standards for ease of use and incorporating the data into the receiving EHRs.*

*All elements in the common clinical data must include unique identifiers that allow EHRs to recognize that information if it is sent subsequently. All EHR vendors MUST be required to implement strategies to de-duplicate information both from repeat senders as well as across different systems to better streamline what is displayed to the clinician.*

*Specifically, rules should be included for “date of data” and how information should be displayed to the user when organizations have conflict information. Like Smoking Status – YES from Organization A, No from Organization B, and Blank from Organization C… which one is most recent and is it from an organization where that data should be trusted? Should there be a way to ‘weight’ more trusted ‘sources’….?*

*Specific interest lies in lab values, imaging results, implants, procedures, and care plans but these would act as the ‘next focus’ to be closely followed by the other elements listed in the clinical data set. Some potential additional values may include: : Proxy for medical decision making (we recommend that it should be considered a separate data field from Care Team and Code status/POLST/advanced directive. Since there is no national standard this may be difficult but we recommend working toward the sharing of these data points in a standard way.*

*We would also like to see standard “directory of Direct addresses” to further aid in the exchange of data. State and Local HIEs, the national HIE, and direct messaging all seem to be fragments of a puzzle and we need ways to improve cross organization communication without it requiring us to pick up the phone and call each of these organizations to discuss the sharing of directories.*

1. Certification and Testing
   1. In what ways can semantic interoperability be best tested? (e.g., C-CDA content and semantics) 6

*Could there be a centralized body/organization that would ‘certify’ the C-CDA/Semantics and unique identification of discrete data so that each “vendor” only had to certify their C-CDA one time (per version). That way customers in the field would not have to test the C-CDA with each customer, HIE, or HL7 group we need to connect with. We need ways to reduce overhead of these implementations to better encourage interoperability and the efficiency of these connections.*

*Health Information Exchanges should also be required to certify the way they exchanges CCDA and if they are in a consolidation model how they merge and manage data across the different vendors.*

1. Measurement
   1. Does the measurement and evaluation framework cover key areas? What concepts are missing?
      1. No Comment
   2. Which concepts from the framework are the most important to measure? What types of measures should be included in a "core" measure set?
      1. Adoption (we need to be able to trust that sources of information are complete and accurate, we need “everyone” participating so that the charts can be as comprehensive as possible).
      2. Standardization (improves implementation speed, improves data quality, improves reporting, and metrics).
      3. Usability – Lessen Information Burden for the clinician
   3. Should measurement focus on certain use cases, priority populations or at certain levels of the ecosystem (e.g., encounter, patient, provider, organization)?
   4. What other types of metrics have been successfully used at the local or regional level that might be considered for nationwide use? Would stakeholders be willing to propose novel metrics and provide "test beds" to assess the potential for nationwide use?
   5. What measurement gaps should be prioritized and addressed quickly?
      1. Focus on participation from all sources of health care data… nursing homes, home care, schools, prisons, etc…
      2. Simultaneously focus on making sure the data from all sources means the same thing.
      3. Then focus on metrics and data so that we can build analytical tools and incorporate the data consistently into our systems.
   6. What other available data sources at the national level could be leveraged to monitor progress?
   7. Are the potential mechanisms for addressing gaps adequate? What are other suggestions?
   8. How should data holders share information to support reporting on nationwide progress?
   9. What are appropriate, even if imperfect, sources of data for measuring impact in the short term? In the long term? Is there adequate data presently to start some measurement of impact?
      1. Certify the EHRs so that the defined standards are interpreted the same way.
      2. Have the EHRs cross certify so that they must prove data sharing.
      3. Have the EHRs prove de-duplicating abilities