Interoperability and Health Information Exchange Workgroup

Micky Tripathi, Chair
Christoph U Lehmann, Co-chair

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IOWG Membership

First	Last Name	Organization
Micky	**Tripathi**	**Massachusetts eHealth Collaborative**
Christoph	**Lehmann**	**Vanderbilt**
Brian	Ahier	Medicity
Beth	Morrow	The Children's Partnership
Arien	Malec	RelayHealth
Larry	Garber	Atrius
Jitin	Asnanni	CommonWell Health Alliance
Tony	Gilman	Texas Health Services Authority
Landen	Bain	CDISC
Shelly	Sprio	Pharmacy HIT Collaborative
Troy	Seagondollar	Kaiser / United Nurses Association of California
Melissa	Goldstein	The George Washington University
Carl	Dvorak	Epic
Marc	Probst	Intermountain
Wes	Rishel	Consultant
Hal	Baker	Wellspan
Dave	Whitlinger	NYeC
John	Blair	MedAllies, Inc.
Kate	Kiefert	State of Colorado
Barclay	Butler	Defense Health Agency
Kitt	Winter	Social Security Administration
Margaret	Donahue	Department of Veterans Affairs
Nancy	Orvis	Department of Defense

HITPC - Interoperability & HIE

Health IT Policy Committee
A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

Workgroup	Interoperability & HIE
ONC FACA WG Lead(s)	Kory Mertz
Chair / Co-Chairs	• Micky Tripathi, Chair, Massachusetts eHealth Collaborative • Christoph Lehmann, Co-Chair, Vanderbilt School of Medicine
General Questions (as they apply to the assigned Roadmap section)	• Are the actions proposed […] the right actions to improve interoperability nationwide in the near term while working toward a learning health system in the long term? • What, if any, gaps need to be addressed? • Is the timing of specific actions appropriate? • Are the right actors/stakeholders associated with critical actions?
Roadmap Section	• M. Accurate Identity Matching • N. Reliable Resource Location
Section Specific Question(s)	• In what ways does the draft approach need to be adjusted to sufficiently address the industry needs and address current barriers? (M. Accurate Identity Matching)

Interoperability and HIE Workplan

Health IT Policy Committee
A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

	Meetings	Task
√	***February 10, 2015 – HITPC Meeting***	• ***Charged by the HITPC with commenting on the Interoperability Roadmap V.1***
√	February 25, 2015 2:30-4pm ET	• Comment on Interoperability Roadmap V.1
√	March 5, 2015 3:30-5pm ET	• Comment on Interoperability Roadmap V.1
√	***March 10th – HITPC Meeting***	• ***Early Interoperability Roadmap Recommendations to HITPC***
√	March 19, 2015 3:30-5pm ET	• Comment on Interoperability Roadmap V.1
√	April 2, 2015 2:30 – 4pm ET	• Finalize Interoperability Roadmap Comments
➡	***April 7, 2015- HITPC Meeting***	• ***Interoperability Roadmap Recommendations to HITPC***
	April 17, 2015 2:30-4pm ET	• Comment on MU3 NPRM
	April 30, 2015 3:30-5pm ET	• Finalize MU3 NPRM Comments
	May 12th – HITPC Meeting	• ***MU3 NPRM Comments to the HITPC***

General Themes (1 of 3)

1. Workgroup recognizes the importance of accurate identity matching and reliable resource location as roadmap categories

2. Concerns raised about
   - Aggregate number & complexity of the "critical actions"
   - Ability of the industry to accomplish actions in the 2015-2017 timeline
     - 36 "critical actions" in these two categories alone
     - 20 "critical actions" in the 2015-2017 timeframe
     - 2015-2017 timeframe should focus on motivating use of requirements put in place by MU Stage 1 and 2
     - New actions should be planned in 2015-2017 but not expected until later

3. The Roadmap articulates an interoperability floor rather than a ceiling (i.e. matching should go beyond the minimum data matching elements).

General Themes (2 of 3)

4. Scope and definition of the "coordinated governance"
   - Half of 2015-2017 Critical Actions rely on policy and operational functions driven by "coordinated governance"
   - "Coordinated governance" is not specifically defined (strategically or operationally) and ambiguous to different current and future levers
   - Lack of specificity on levers/incentives to accomplish each Critical Action
   - **WG unable to endorse or reject critical actions relying on "coordinated governance"**

General Themes (3 of 3)

5. The Roadmap should include Record Location as a long-term goal based on identity-matching and resource location capabilities
   - Private data-sharing arrangements are already deploying such services today (CommonWell, MA HIway, etc)
   - Potential opportunity for CMS to launch Medicare-focused Record Location Services based on existing claims and HITECH data?

Accurate Individual Data Matching

Accurate Individual Data Matching (1 of 3)

1. **Technical standards are necessary but not sufficient to establishing accurate and reliable patient-matching**
   - Requires a combination of technical standards and aligned business processes
   - Such business processes may be established "upstream" of a provider entity, for example, as part of a data-sharing arrangement

2. **There is value in communicating a best practice "minimum" set of standardized data elements for patient-matching, however, such a set should not be required for patient-matching, nor should it be the basis for defining MU or EHR certification requirements**
   - The 2015 Edition EHR Certification NPRM proposes requiring most of the Roadmap minimum data set recommendations
   - Best practice suggests using as many of the "minimum" data set elements as available and appropriate to the specific use case and/or data-sharing arrangement
   - Use of "minimum" set for patient-matching NOT mandatory due to high variation in data availability, data quality, and use-case appropriateness
   - Inclusion of voluntary elements for elements at the discretion of the entity – too much existing variation in data and use-case circumstances to set top-down requirements

Accurate Individual Data Matching (2 of 3) - mapping of Roadmap minimum matching data elements to certification

Interoperability Roadmap proposed minimum recommended data elements to be standardized	2014 Edition (Common MU Data set/record demographics)	2015 Edition NPRM (Create a ToC)
First/Given Name	√	√
Current Last/Family Name	√	√
Previous Last/Family Name	--	√ *(maiden name)*
Middle/Second Given Name (includes middle initial)	--	√
Suffix	--	√
Date of Birth	√	√
Current Address (street address, city, state, ZIP code)	--	*Included but not standardized*
Historical Address (street address, city, state, ZIP code)	--	*Included but not standardized*
Current Phone Number (if more than one is present in the patient record, all should be sent)	--	√
Historical Phone Number	--	--
Gender	√ *(sex)*	√ *(sex)*
- -	--	*Adds: place of birth*

Accurate Individual Data Matching (3 of 3)

3. **Locally driven data governance, such as data-sharing arrangements as defined by the JTF, should be the prime motivators for use of the minimum data set and addressing technical and business requirements beyond the minimum set**
   - Data assurance – which source is the source of truth?
   - Data quality – how are emerging issues resolved and maintained?
   - Voluntary data elements – highly dynamic and dependent on local capabilities
   - Clinical, business, and legal accountability – who is responsible for what?

4. **ONC can play a valuable role in convening implementers to identify and share best practices and lessons learned**
   - Work done under S&I framework and in specific transaction areas (e.g., PDMPs) should be shared and leveraged where possible

5. **Critical action item M2.1 should be moved from 2015-2017 to the 2018-2020 timeframe.**
   - M2.1 Through coordinated governance, public and private stakeholders should develop and pilot tools and technologies for establishing performance metrics for individual identity, query and internal individual matching/record linking.

Additional Data Elements Discussed

- Mobile Phone number(s)
- Email address(es)
- Place of Birth
- Social media ID (Facebook, Apple, Google, etc)

Reliable Resource Location

Reliable Resource Location N1 Continued (emphasis added by IOWG)

N1. 2015-2017 Send, receive, find and use a common clinical data set	
1.	Through coordinated governance, public and private stakeholders should **identify the architecture and workflow for resource location** as part of a learning health system, including the individual and IT system actors, roles and access requirements.
2.	Through coordinated governance, public and private stakeholders should **prioritize the participants and services that are to be discoverable** using resource location and identify a near-term goal for the first small set of resources to be included in an initial implementation.
3.	From the architecture, SDOs and health IT developers should **determine or develop standard(s) and API(s) for discovering participants and resources** (including other directories if the architecture is federated), determine whether any of the current standards or legacy services already incorporated in products can be used or extended and develop a Roadmap to implementation of new standard(s) and API(s), if necessary.
4.	Through coordinated governance, public and private stakeholders should **identify rules of the road for participating in distributed management of resource location**, if appropriate for the architecture and actors. This includes establishing policies and procedures for operation of resource location services, including curation of directory information to maintain data quality.
5.	Through coordinated governance, public and private stakeholders should work with SDOs and health IT developers to **demonstrate standard(s) and API(s) in a trial implementation**, beginning with the prioritized set of resources.

Reliable Resource Location (1 of 2)

1. **Most of the Reliable Resource Location Critical Action Items cannot be accomplished in the 2015-2017 timeframe and should be moved to 2018-2020 or beyond**
   - Critical Action items are a sensible set of steps, however, lack of mature provider directory standards and common business practices is a large barrier
   - Appropriate to include N1.1 as a near-term goal
   - For N1.1, remove the focus on a learning health care system for the 2015-2017 timeline – not well-enough defined to drive near-term actions
   - N1.2-5 should be moved from 2015-2017 to 2018-2020.

2. **Reliable Resource Location needs to be focused on specific use cases**
   - Different use cases and problems will drive different technical and business requirements

Reliable Resource Location (2 of 2)

3. **The WG supports the various ONC initiatives contained in N2**
   - Concerns that ONC and CMS do not have the resources to undertake all of these Critical Action items in the 2015-2017 timeframe

4. **The WG supports adding Direct addresses and ESI information to NNPES and making NPPES information openly available to support Resource Location**
   - Recommend that this be done in the spirit of an Open Data Initiative rather than as a provider directory service – allow open access to the data via common industry data standards and let the market define services and uses