Electronic Healthcare Network Accreditation Commission

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Health & Human Services
Office of the National Coordinator
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ATTN: Draft 2017 Interoperability Standards Advisory

Dear Interoperability Standards Advisory:

Founded in 1993, the Electronic Healthcare Network Accreditation Commission (EHNAC) is an independent, federally recognized, standards development organization and tax-exempt, 501(c)(6) non-profit accrediting body designed to improve transactional quality, operational efficiency and data security in healthcare.

COMMENTS:

Section I: Vocabulary Code Set/Terminology Standards and Implementation Specifications

EHNAC recognizes that these standards are limited by the work of a number of individual organizations and that the standards are a work in progress. The data and subsequent information contained in an electronic record or transaction must rely on uniform vocabulary and translation if the information from the site of care, conversation with the patient, and entry of other diagnostic and observation data is to be understood by the recipient (or reader). This reader can be another clinician or the patient. Failure to provide uniformity and to include elements that accurately describe the tangible facts or conversations, can lead to inappropriate care and increase patient safety concerns as well as affect third-party operations such as research, public health and reimbursement.

In some cases, the draft suggests that more than one standard might be used for a single function due to locations (e.g. hospital v practice). We do not believe that locations of service should be a factor in the use of a standard. Rather, standards should be expanded to cover the complete course of care. For too long reimbursement concerns have affected clinical-based standards and this impairs true interoperability.

Specific Comments:

I-A: Allergies:

- This section uses a variety of terminologies and classifications and while all of these come under the purview of the National Library of Medicine, many are not commonly known by healthcare providers. As our industry moves toward a desired interoperability, it would behoove ONC to consider educations to begin to familiarize the healthcare community in general and specifically clinicians as to the content and purpose of these standard, even if they would not be used directly in the future. As electronic health records and similar e-health software mature, providers will be faced with adopting various hardware, software, and communications products and should be aware of what expectations they should have of vendor products.
- As interoperability moves forward, it would behoove vendors to adopt standards such as these to achieve interoperability; however, we note that there is concern that some of these standards are incomplete or questionable for the function they are to fulfill. For instance, you note that SNOMED-CT® does not cover all the needs for allergies. It would benefit vendors and provider to know what steps ONC, the NLM, and other agencies are taking to ensure the respective standards bodies are filling the need for additional terminologies, classifications, and so forth. If gaps exist to any extent it slows down adoption.

I-B: Encounter Diagnosis

- It would appear that the SNODENT terminology is incomplete. It would help if ONC was more specific about its concerns so that the standards organization could respond. ICD-10-CM should be noted as a wide-spread standard in use today.

I-C: Family Health History

- It would appear that this interoperability standard is premature, given the incomplete LOINC project and the limitations in SNOMED-CT. Given the link between family history and exchange with patient portals and patient health record systems (PHRs), EHNAC is concerned that more emphasis need to occur to move both identified standards forward both to develop a standard and encourage individuals to develop and exchange family histories for well know purposes.

I-D: Patient Functional Status and Disability

- We understand some of the restraints on SNOMED-CT, but confused that you have not considered the World Health Organization's International Classification of Functionality which has been in use for some time and discussed in the National Committee for Vital and Health Statistics (NCVHS). Besides being a classification that could be implemented sooner than later, it would also be beneficial for the interoperability of healthcare knowledge across the globe. We suggest a discussion with the ICD-10-CM staff at the National Center for Health Statistics.

I-E: Health Care Provider

- It is not clear to what degree this information is needed. We are aware of different provider identifiers including the National Provider Identifier (NPI). For interoperable purposes, the identification of the physician of record (which could change over the course of care even in a single episode, might be sufficient; however, if vendors are to develop systems that identify all provider staff involved in the care, diagnosis, etc., of the patient, such as would be required for a access report under HIPAA standards, then each employee, volunteer, agent, medical student, etc., would need to be addressed. It might be feasible to develop an identifier for the provider (hospital, agency, clinic, practice, etc., that could be combined with an identifier of a fixed length (alpha-numeric) that could reside with the provider so if additional information about a staff member other than the physician of record were needed, the individual(s) could be identified. It should be considered that and identification system that could eventually be consistent across providers (without necessarily being a national identifier for each employee et al.) could serve internal purposed including not only reporting under HIPAA, but also for internal analysis, patient safety, and other information purposes.
- The NPI should be noted as a wide-spread standard in use today.

I-F: Imaging:

- The standards recommended have been in use for some time and do not require comment.

I-G: Immunizations

- The codes listed have been used for some time in the US and are incorporated by the HL7. Given the recent concern with a variety of outbreaks across the globe we do hope you will consider cross tables so that immunizations in other countries can be accessed if needed when an individual presents their US credentials and immunization is questioned.
- This is another situation, where the standards adopted should also be included in patient portal and PHR products.

I-H: Industry and Occupation

- It is apparent that ONC and its department, agency, and office federal colleagues should work to adopt a common set of industry and occupation codes. We are aware that occupation codes are limited and perhaps should be expanded. We are also aware that Depart of Labor codes take years to update, while occupations change more rapidly. Therefore, we suggest that in addition to working together across federal entities, this cooperative effort also enlist the cooperation of professional organizations and unions to identify new occupations for which a new universal (US) code could be adopted on a periodic basis.

I-I: Lab Tests

- LOINC and SNOMED-CT have been used successfully for years and we see no reason at this time to change or expand terminologies in this area.

I-J: Medications

- No comment.

I-K: Numbers References & Values

- EHNAC recognizes some of the concerns raised and again suggests an inter-agency/professional solution. While numerical representation has been fairly uniform within healthcare entities; we again raise the concern of the ability to transmit numerical reverences and values between healthcare entities and portal and PHR systems, in order to allow communications that include such numbers as understood by provider and patient.

I-L: Nursing Terminologies

- The issue of nursing terminologies has been lingering for several years. It would behoove ONC to initiate a project with the American Nursing Association (AHA), LOINC, and the NLM (SNOMED-CT liaison) to address the need to consolidate terminologies for consistency with other terminologies and classifications.

I-M: Patient Clinical "Problems:

- No comment – agree.

I-N: Preferred Language

No comment – agree.

I-0: Procedures

- At present the suggested terminology (SNOMED-CT) and the three classifications (CDT, CPT®/HCPCS, and ICD-10-PCS) are appropriate. However, for the purposes of interoperability and data/information analytics consolidation to a single classification, in addition to the more detailed terminology should occur. The current use of classification by location does not make sense in the long run for the exchange of clinical information, but it may not be feasible to use a terminology only.
- The ICD-10-PCS is a wide-spread standard in use today.

I-P: Race and Ethnicity

- The use of CDC, OMB, and LOINC is acceptable.

I-Q: Research

- The CDISC is acceptable.

I-R: Sexual Orientation of Gender Identity

- It appears that the LOINC, SNOMED-CT, and HL7 Version 3 cover this area appropriately.
- It will be important to recognize that should PHRs or patient portals provide a patient oriented response to this questions there could be a conflict with that in other records.

I-S: Social Determinates

- It appears that until the LOINC project is complete any standard in this category is premature.

I-T: Tobacco Use

- It might be appropriate to seek additional SNOMED terms, rather than relying on two different terminologies.

I-U: Unique Device Identification

- While UDI is not pervasive, we now understand that all devices do have a code. As communication between these devices and the EHRs as well as potentially the PHR increases it will be very important that all software carry the same code set, for patient safety, care, and research.

I-V: Vital Signs

- The LOINC terminology will have to be the part of any patient portal or PHR communication.

Section II: Content/Structure Standards and Implementation Specifications

EHNAC recognizes that these standards are limited by the work of a number of individual organizations and that the standards are a work in progress.

Specific Comments:

II-A: Admission, Discharge and Transfer

- The HL7 approach is acceptable.

11-B: Care Plan

- The HL7 plan is acceptable and patient portal and PHR vendors should incorporate these standards into their products so that care plans can be received by the patient.

II-C; Clinical Decision Support

- Given that that HL7 standard is in ballot it is good to announce a potential solution, but not to suggest that this is the standard.

II-D: Clinical Quality Measurement

- While the transaction standards and guides (HL7) are in ballot and may be changed EHNAC is concerned with how these standards and the code sets that may be employed will impact third-party reimbursement. We recognize these are clinical standards but we also recognize that the measurements themselves have not reached consensus by the healthcare community.

II-E: Clinical Quality Reporting

- While it is appropriate for the healthcare community to understand the impact of current HL7 development and balloting on these standards; the nature of their impact should be a cause for more community discussion, similar to that needed for consensus in II-D.

II-F: Data Provenance

- The HL7 approach is acceptable.

II-G: Drug Formulary and Benefits

- Though it is noted that testing tools are not readily available, systems such as Surescripts do allow for testing through intermediary paths to ensure production transactions will process seamlessly. Practices such as that, should continue.

II-H: Electronic Prescribing

- Utilization of the NCPDP Script standard should continue.

II-I: Family Health History

- EHNAC has no comment on this section

II-J: Images

- EHNAC has no comment on this section

II.K: Laboratory

- EHNAC supports the use of the HL7 standards in this area.

II-L: Medical Device Communication to Other Information Systems/Technologies

- EHNAC has no comment on this section.

II-M: Patient Education Materials

- EHNAC supports the use of the HL7 standards in this area.

II-N: Patient Preference/Consent

- EHNAC has no comment on this section.

II-O: Public Health Reporting

- EHNAC supports the use of the HL7 Clinical Document Architecture format for reporting public health activity.

II-P: Representing Clinical Health Information as a "Resource"

- EHNAC has no comment on this section.

II-Q: Research

- EHNAC has no comment on this section

II-R: Segmentation of Sensitive Information

- EHNAC supports the use of the HL7 standards in this area.

II-S: Summary Care Record

- EHNAC has no comment on this section

Sincerely,

Lee Barrett, Executive Director

Cc: EHNAC Commission