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2015 Interoperability Standards Advisory

Request for Comment Response

May 1, 2015



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Introduction

Accenture strongly supports ONC's goals of identifying the best available standards and implementation specifications, outlined in the *2015 Interoperability Standards Advisory*. From Accenture's leadership role in Health IT and our long-standing support of ONC programs, including the Standards and Interoperability Framework, we appreciate the value a comprehensive list of standards and implementation specifications can provide to the government, healthcare industry, and citizens. As a global consulting company with more than 600 clients from leading healthcare providers, payers, public health, and life sciences organizations, Accenture feels that interoperability is an important business priority for our high performing clients and will help them ultimately provide better healthcare and services to their customers. We applaud ONC for providing the healthcare industry with a strategic direction and forum to collaborate on how to best accomplish critical interoperability tasks.

Accenture commits to helping ONC in their mission of advancing healthcare through interoperability. We can act as a conduit between ONC and our healthcare clients. Accenture can serve as a trusted sounding board for ONC regarding how policy decisions might impact the healthcare industry, leveraging our understanding of our clients and their challenges in the current healthcare system. We can also inform our healthcare clients of the 2015 Interoperability Standards Advisory and the objectives set forth by ONC, and of other nationally recommended standards that should be considered for the implementation of health IT. Additionally, Accenture has a strong relationship with several Standards Development Organizations. Accenture is an HL7 Benefactor member. Benefactor membership is HL7's highest class of membership for those who are willing to support HL7's mission. The membership also gives Accenture all of HL7 member benefits and the maximum number of voting members. We also recently became a sponsor of the Argonaut project. The purpose of the Argonaut Project is to rapidly develop a first-generation FHIR-based API and Core Data Services specification to enable expanded information sharing for electronic health records and other health information technology based on Internet standards and architectural patterns and styles. We also participate in IHE, IHTSDO, CDISC, WEDI, NCVHS and SDO Charter Organization (SCO) workgroup meetings. In Accenture's role as the Standards Development Support team within the Standards & Interoperability Framework, we have leveraged Accenture's relationships with standards organizations to support ONC with S&I specific outreach. We are committed to connecting ONC with our relevant healthcare clients and standards organizations, to help strengthen collaboration in support of interoperability.

Accenture appreciates the opportunity to provide this commentary to the 2015 Interoperability Standards Advisory and look forward to this ongoing annual process. We recognize the significant impact the Standards Advisory will have for both the private and public health sectors and ultimately citizens. In addition, we would welcome the opportunity to discuss our comments and recommendations with you in further detail.

Accenture's Answers to Questions Posed Regarding the Interoperability Standards Advisory

Section V: Questions Regarding the Interoperability Standards Advisory

5-1 [General] *What other characteristics should be considered for including best available standards and implementation specifications in this list?*

In addition to the five “best available” characteristics listed, we have identified the following additional characteristics for ONC’s consideration:

- The standard or implementation specification is compatible with other selected standards and implementation guides as well as with the roadmap and strategic framework or architecture. Without this compatibility, we will continue to have stove pipe exchanges, requiring health IT systems to support multiple data capture and data exchange capabilities, rather than leveraging and reusing data.
- The standards or implementation specifications go through a validation process where it is determined if the standards are capable of being used together. It should be clear as part of the communication as to how widespread adoption of the standard is. For example, the selection of an HL7 v2 message where the domain require a post coordinated vocabulary, presents a mismatch because the coded data type cannot carry such a vocabulary element.
- The standard or implementation specification is published and publically accessible.
- The standard or implementation specification is confluent with the most rigorous state reporting and compliance and regulatory requirements (e.g., 10D-3 in Florida).
- The standard or implementation specification aligns with the best IT practices across industries.
- Consideration should be given to the standard or implementation specification being able to be adopted internationally.

We suggest adding the following factor to the list of “Additional Factors Affecting Best Available Determinations”:

- **Usability & Visibility to Cost** – usability relates to enabling people to make better decisions on healthcare purchases and reduce how much they spend on those purchases. Greater visibility relates to helping them compare apples to apples as they make their healthcare purchases based on outcomes.

5-2 [General] *Besides the four standards categories included in this advisory, are there other overall standards categories that should be included?*

Yes – in addition to the four standards categories included in this advisory, we identified the following standards categories to consider as well:

- **Data capture.** Interoperability specifications should consider a standard for data capture. One cannot construct longitudinal data records for analysis without understanding the terminology and its membership in value set’s and relationships to specific data elements in the user interface. We need to emphasize that the semantics need to convey the context in which this information is communicated and interpreted.
 - **Example:** If a person’s status is currently that of a non-smoker, does the information shared convey the understanding that they have been a smoker for the last 20 years? What are the socio-determinants of today vs. 5 years vs. 20 years?
- **Security standards.** There should be more in depth and attention to security standards. There are more considerations than the transport security standards referenced in the Interoperability Standards Advisory.
 - **Example:** Digital certifications and encryption.

5-3 [General] *For sections I through IV, what “purposes” are missing? Please identify the standards or implementations specifications you believe should be identified as the best available for each additional purpose(s) suggested and why.*

In addition to the “purposes” already listed in Sections I through IV, we identified the following additional purpose to consider adding as well:

Purpose	Standard(s)	Implementation Specification(s)
Cancer Staging	TBD	TBD

5-4 [General] *For sections I through IV, is a standard or implementation specification missing that should either be included alongside another standard or implementation specification already associated with a purpose?*

Yes - We recommend including SNOMED-CT to the 2015 version of Standards Advisory. The “standard” is a foundation that a skilled developer needs to turn into a “tight” implementation guide. There will need to be an unambiguous implementation guide for every use case that needs to be supported. Further work may be required that is unique to the vendor systems in place and the internal IT architecture of each provider organizations IT infrastructure. Furthermore, IT documentation, testing beds and procedures and nation-

wide standard revision levels for terminologies will also have to be carefully managed to current levels.

In addition to the standards and implementation specifications associated with the purposes that are already listed in Sections I through IV, we identified the following standards to consider including as well:

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

Purpose	Standard(s)	Implementation Specification(s)
Food allergies	SNOMED-CT	TBD
Functioning and disability	SNOMED-CT	TBD

5-5 [General] *For sections I through IV, should any of the standards or implementation specifications listed thus far be removed from this list as the best available? If so, why?*

Yes - All are credible and need to be put through a set of structured trials to make sure that the different selected messaging and terminology standards and revision level will produce the needed accurate interoperation of process and data.

For Sections I through IV, we identified the following standards to consider removing from the list:

Purpose	Standard(s)	Implementation Specification(s)
Care team member (health care provider, non-physician ancillary providers)	National Provider Identifier (NPI)	TBD
Encounter diagnosis	ICD-10-CM	TBD
Immunizations – administered	National Drug Codes (NDC)	TBD

- For the purpose of “Care team member (health care provider)”, Care team members should include non-physician ancillary providers – these members of the care team don’t necessarily have a NPI. Therefore, NPI may not be the appropriate standard to identify care team members.
- For the purpose of “Encounter diagnoses”, we recommend that ICD-10-CM be removed. We recommend this because having more than one standard creates the

need to do mapping which opens up interpretation of matching concepts to one another to an individual's preference. This defeats interoperability.

- For the purpose of “Immunizations – administered”, we recommend that National Drug Codes (NDC) be replaced with RxNorm as the standard. NDC code should never be used in data capture for a number of reasons including ambiguity in representation as well as the reuse of codes by manufacturers.
- General note: While use of HL7 V3 messaging may have narrow niche roles, their inclusion is probably not on a roadmap for extension and one might consider flagging interest in alternatives, such as FHIR messages.

5-6 [Section I] *Should more detailed value sets for race and ethnicity be identified as a standard or implementation specification?*

No. The value sets need to be clearly defined, and updated regularly. Given that this is a very sensitive area, we found that at the moment the best option is to go with the value sets for race and ethnicity that are in prevalent use. There is not a great alternative, just an alternative with different issues. This should be left to an implementation guide given that as genomic data becomes more readily available, our concept of ethnicity will fall away as antiquated. Detailed value sets should be identified as an implementation specification, to allow the same standard to be used for multiple use cases.

5-7 [Section I] *Should more traditionally considered “administrative” standards (e.g., ICD-10) be removed from this list because of its focus on clinical health information interoperability purposes?*

No – we do not recommend removing more traditionally considered “administrative” standards. ICD-10 serves a broad use and purpose especially in the Healthcare Payer and Provider/Payer IT market segments. Clinical context is often reliant on an administrative under-layer.

5-8 [Section I] *Should “Food allergies” be included as a purpose in this document or is there another approach for allergies that should be represented instead? Are there standards that can be called “best available” for this purpose?*

Yes – we recommend including “Food allergies” as a purpose in the document. SNOMED-CT should be listed as the “best available” standard for this purpose. In addition, we recommend separating food intolerance from actual food allergy.

5-9 [Section I] *Should this purpose category be in this document? Should the International Classification of Functioning, Disability and Health (ICF) be included as a standard? Are there similar standards that should be considered for inclusion?*

Yes – the “Functional and disability” purpose category should be included in the document and the ICF should be included as a standard for this category. A similar standard that could be considered for inclusion is SNOMED-CT as it would simplify implementation and give a more robust classification and maintenance process.

5-10 [Section I] *Should the MVX code set be included and listed in tandem with CVX codes?*

No – we do not recommend including the MVX code set and listing it in tandem with CVX codes. The MVX code system is not updated frequently enough to reflect the constant merger and acquisition of Pharma companies where the manufacturer may change. Furthermore, MVX should not be used given that the data that will be available indirectly through RxNorm. RxNorm has a much better refresh rate and carries with it the necessary data for someone to look up a manufacturer at a point in time.

5-11 [Section I] *Public health stakeholders have noted the utility of NDC codes for inventory management as well as public health reporting when such information is known/recorded during the administration of a vaccine. Should vaccines administered be listed as a separate purpose with NDC as the code set?*

Yes - Vaccines administered could be listed as a separate purpose, however, if listed as a separate purpose, NDC would not be the correct code set to use. We recommend using RxNorm or sticking to CVX or CVX /MVX.

5-12 [Section I] *Is there a best available standard to represent industry and occupation that should be considered for inclusion in the 2016 Advisory?*

Yes – we recommend that the Standard Occupational Classification (SOC) codes be used as a “best available” standard to represent industry and occupation in the 2016 Advisory.

5-13 [Section I] *If a preferred or specific value set exists for a specific purpose and the standard adopted for that purpose, should it be listed in the “implementation specification” column or should a new column be added for value sets?*

No – we do not recommend adding a new column for value sets. If a preferred or specific value set exists for a specific purpose and the standard adopted for that purpose, it can be listed in the “implementation specification” column. If a preferred or specific value set exists for a specific purpose and the standard adopted for that purpose, we recommend that it be listed in the “implementation specification” column. Since the value sets will need

to be changed over time in referencing the value set, it would only be useful where it is intentionally defined. If a corresponding value set applies then a reference to the value set, a URL link if appropriate and available as well publication and revision level identification should be included.

5-14 [Section II] *Several laboratory related standards for results, ordering, and electronic directory of services (eDOS) are presently being updated within HL7 processes. Should they be considered the best available for next year's 2016 Advisory once finalized?*

Yes – HL7 v2 messaging is what is currently in broad, national use and it is unrealistic to go away from it right now. The reference lab industry settled on the HL7 2.5.1 standards with implementation guides several years ago. The current activities in HL7 are to update these standards, implementation guides, and any changes necessary to value sets associated with these implementations. However, for the future, a switch to CDA or FHIR should be considered and they should be listed as alternative mechanisms of transport to allow gradual deprecation of HL7 v2 messaging.

Electronic directory of services (eDOS) should be considered best available for 2016 once finalized. This will save significant time and effort for providers to manage the master data and lab services offered by labs.

5-15 [Section II] *Are there best available standards for the purpose of "Patient preference/consent?" Should the NHIN Access Consent Specification v1.0 and/or IHE BPPC be considered?*

Yes – we suggest considering the outcomes of the HL7 Patient Friendly Consent project for the purpose of "Patient preference/consent". IHE BPPC should be considered as the support for varying levels of confidentiality is needed.

5-16 [Section II] *For the specific purpose of exchanging behavioral health information protected by 42 CFR Part 2, does an alternative standard exist to the DS4P standard?*

No – we are not aware of an alternative standard that exists to the DS4P standard. However, we do recommend extensive piloting to determine how it works with secondary disclosures, information incorporated into new documents and disruption of workflow be investigated.

5-17 [Section II] *For the 2015 list, should both Consolidated CDA® Release 1.1 and 2.0 be included for the "summary care record" purpose or just Release 2.0?*

Yes – we recommend in terms of the 2015 Interoperability Standards Advisory including both Consolidated CDA Release 1.1 and 2.0 for the "summary Care Record" purpose. We

recommend this since C-CDA R1.1 adoption has grown exponentially and since systems using C-CDA R1.1 will not quickly move to version 2.0. However, in terms of future Interoperability Standards Advisories, we would recommend listing C-CDA Release 2.0 solely as the “summary Care Record” purpose standard.

5-18 [Section IV] *Should specific HL7 message types be listed? Or would they be applicable to other purposes as well? If so, which ones and why?*

Yes – HL7 message types should be listed. There are HL7 v2 message equivalents for many of the IHE profiles defined in this section. Given the wide adoption of HL7 v2 messaging, we should allow for them. There should also be an option for FHIR to allow vendors to slowly deprecate HL7 v2 messaging.

For more information

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