

# **OCHIN, INC.**

## **Feedback: ONC 2016 Interoperability Standards Advisory**

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### **Overview**

Thank you very much for providing this opportunity for stakeholder feedback on the 2016 Interoperability Standards Advisory.

Our work as both a Health Centered Control Network (HCCN) supporting federally-qualified health centers (FQHCs), and as Oregon's Regional Extension Center has provided us with a wealth of information about the challenges facing practices around the country as they implement health information technology and attempt to expand their connections with other providers. We think that the new format of the 2016 Interoperability Standards Advisory will help technical assistance providers and vendors provide better service to practices, though we remain concerned that many practices don't have the level of technical expertise to decipher most of the document themselves. While this is probably beyond the scope of this document, we think that many practices would benefit from a definition of best practices, or a best practices guide, on how to migrate from a poor or older standard to a new or more widely adopted standard. And the more that ONC can help all of us move to one unified standard, the more we will be able to implement interoperability across the health care landscape.

### **OCHIN Background**

OCHIN, Inc., a nonprofit organization headquartered in Portland, Oregon was created in 2000 to provide centralized support for the implementation and maintenance of electronic health records (EHRs) for federally-qualified health centers (FQHCs). OCHIN engaged the primary care community in Oregon to initially create its highly customized, centrally hosted ambulatory Epic EHR. OCHIN's membership now includes primary care organizations in 18 states that employ more than 4,500 medical professionals and care for over 1.2 million patients.

OCHIN has served as Oregon's Regional Extension Center, and through that program supported small practices across the state in onboarding to certified EHR technology (CEHRT). We will be continuing this work with Medicaid providers through a contract with the State of Oregon. Through our work with small practices, we have gained an appreciation of how challenging it is for these practices to navigate working with their vendors to achieve interoperability.

OCHIN has matured during its first decade from a technical services provider into a data- and research-informed quality improvement organization, specializing in primary care and outpatient settings. We provide technical assistance and opportunities to participate in quality improvement and measurement activities, including data analytics and quality reporting services, research, and peer-to-peer learning. OCHIN has 15 years of experience providing technical assistance to health care organizations, health plans, health care providers, and local public health agencies, including work with interface implementation and interoperability support.

## General

4-1. *In the 2015 Advisory, each standard and implementation specification was listed under a “purpose.” Prior public comments and HIT Standards Committee [recommendations](#) suggested that the Advisory should convey a clearer link to the ways in which standards need to support business and functional requirements. This draft attempts to do so and lists standards and implementation specifications under more descriptive “interoperability needs.” Please provide feedback on whether revision from “purpose” to “interoperability need” provides the additional requested context and suggestions for how to continue to improve this portion.*

The change from “purpose” to “interoperability needs” has added clarity to the document. In sharing the draft with clinical staff there were some questions about whether I-C: Encounter Diagnosis should be broken into Visit/Encounter Diagnosis and Discharge Diagnosis to accurately capture the patient problem being addressed, but in general the structure around “interoperability need” is an improvement over the 2015 document structure.

4-2. *For each standard and implementation specification there are six assessment characteristics. Please review the information provided in each of these tables and check for accuracy. Also, please help complete any missing or “unknown” information.*

We reviewed the information and think that the addition of the six assessment characteristics is a major improvement over the previous version. We believe that you have achieved your goal for this document “to provide clarity, consistency, and predictability for the public regarding ONC’s assessment of the best available standards and implementation specifications for a given interoperability need,” at least for those organizations with adequate technical expertise.

We found the new approach to be very useful, and applaud ONC’s work to capture the assessment characteristics. We anticipate that this format, including the implementation maturity and adoption level, will help us in conversations with potential partners about how we can best achieve interoperability between our systems.

However, we do have one minor comment. At least one of our reviewers found the “Regulated” column a bit counterintuitive. It may suggest that the standard being discussed is either regulated by some body or is not, especially for someone who just scans the descriptions of the characteristics. Perhaps it should be labeled “HHS Regulated” or “HHS Required” to achieve greater clarity.

4-3. *For each standard and implementation specifications, there is a table that lists security patterns. This draft only includes select examples for how this section would be populated in the future. Please review examples found in Sections III-A*

*and III-F and provide feedback as to the usefulness of this approach and any information you know for a specific interoperability need.*

We think that this is a useful approach. However, we think it would be strengthened by highlighting the necessary alignments between technical standards and HHS requirements for programs such as Meaningful Use (MU). For example, there should be language in III-D that links back to III-A that addresses the limitations and lack of agreement around the HPD standard and the limitations of basing a MU requirement on draft specifications that may change. Providers, particularly from small practices, need to understand the dynamic environment and the difficulty of implementing new technology standards within the allowable timeframe to meet data collection periods for MU.

*4-4. For each interoperability need, there is a table beneath the standards and implementation specifications that includes limitations, dependencies, and preconditions. This draft only includes select examples for how this section would be populated in the future. Please review populated sections and provide feedback as to the usefulness of this approach and any specific information you know for a specific interoperability need.*

The section on “Limitations, Dependencies, and Preconditions for Consideration” will be particularly helpful for our future planning. We would encourage ONC to expand the information included for all appropriate interoperability needs. As we stated above, adding links highlighting dependencies between the standards for different interoperability needs will be particularly important.

## **Section I: Vocabulary/Code Set**

*4-5. Based on public feedback and HIT Standards Committee review, there does not appear to be a best available standard for several “interoperability needs” expressed in this section of the draft Advisory. Please provide feedback on whether this is correct or recommend a standard (and your accompanying rationale).*

While code sets are important, they don’t always fix the problem if they don’t match exactly. The important step is for one set to be chosen and improved over time.

One area where improvement is needed in the standards is I-Q: Smoking Status. In addition for the need to capture the severity of dependency as currently stated, there is a more basic need to capture the level of use of tobacco.

Either through I-K: Medications or an additional item, we also need standards for capturing information about alcohol use and non-prescription/over-the-counter drug use. At this time, there is no standard way that clinicians are capturing that information in the health record.

## **Section II: Content / Structure**

We don't have any specific comments on this section.

- 4-6. *Should more generalized survey instruments such as the IHE Profile Retrieve Form for Data Capture be considered?*
- 4-7. *In addition to the two interoperability needs already listed, are there others that should be included related to imaging? If so, what would the best available standard and/or implementation specifications be?*
- 4-8. *Should a more specific/precise aspect of DICOM be referenced for the implementation specification for this interoperability need?*
- 4-9. *The HIT Standards Committee recommended to ONC that clearer implementation guidance is required. Are there additional implementation specifications that should be considered for this interoperability need?*

## **Section III: Services**

- 4-10. *The 2015 Advisory's Section III, Transport has since been removed with content representation migrated as applicable within Section IV Services. What is your view of this approach?*

We support the change in format.

## **Appendix II: Sources of Security Standards**

- 4-11. *Are there other authoritative sources for Security Standards that should be included in Appendix II?*

You might consider adding the following to the list of those included in the draft:

- The FISMA standards <https://www.congress.gov/bill/113th-congress/senate-bill/2521>
- HIPAA Security regulations that are specific to healthcare:  
<http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityrulepdf.pdf>

In addition, we think that a security best practices guide would be very helpful, particularly for smaller practices. The Security Standards you have listed are very comprehensive, but are not particularly user friendly, and can be especially challenging for smaller practices without technology staff to decipher.

## **Additional Comments:**

Support of time zones are needed for all interfaces. We have found that daylight savings time changes can cause significant issues, and we would recommend that Greenwich Mean Time be required in standards.

Several of our reviewers raised concerns about the use of the National Drug Code (NDC) standard because the NDC regularly reuses its codes, making tracking a historic record impossible. Whenever possible, we would recommend only using RxNorm.

Thank you again for this opportunity.