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Dr. DeSalvo:

We are writing on behalf of Ochsner Health System to provide comment on the Office of the National Coordinator for Health Information Technology's (ONC) "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap" (the Roadmap). Ochsner appreciates ONC's work in this critical area. As the healthcare industry makes the important transition from volume-based toward value-based payment models, harnessing the power of a robust health IT infrastructure is crucial.

Ochsner Health System:

Ochsner Health System is one of the nation's leading non-profit health systems, offering a comprehensive range of services through its network of 13 owned, managed and affiliated hospitals and more than 50 health centers or clinics located throughout southeastern Louisiana and Mississippi; 2,200 affiliated physicians, including 1000 employed Ochsner physicians practicing in more than 90 medical specialties and sub-specialties; and, more than 15,000 employees. Ochsner is the only Louisiana hospital recognized by U.S. News & World Report as a "Best Hospital" across nine specialty categories. In 2014, Ochsner cared for patients from all 50 states and more than 90 countries.

Ochsner is an integrated health system that operates on a single electronic health record (EHR). We began our transition from a legacy EHR in 2011 and have deployed our Epic based system across nine of our hospitals. In November 2014, Ochsner Medical Center – North Shore became the first hospital across Louisiana, Mississippi, Alabama, Arkansas and Tennessee to receive the HIMSS Analytics Stage 7 Award, which represents an advanced patient record environment.

Ochsner Comments:

Below, please find Ochsner's comments on the Roadmap. We have formatted our comments in response to the questions posed in the document.

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?

Ochsner agrees the actions (summarized in Figure 2) are the right actions to improve interoperability. We would also observe that all of the actions are required and that accomplishing all of them in the 2015-2017 window will be very challenging. Furthermore, this infrastructure is necessary to achieve the related Objectives proposed for Meaningful Use Stage 3. Failure to make satisfactory progress jeopardizes a 2017-2018 start date for Meaningful Use Stage 3.

2) What, if any gaps need to be addressed?

   We don't believe the Roadmap has left functional gaps, but based on Ochsner's Stage 2 experience, we believe the time frame is very aggressive.

3) Is the timing of specific actions appropriate?

   Yes, as identified in the Roadmap, it is imperative that progress is made simultaneously and in a coordinated manner on all actions.

4) Are the right actors/stakeholders associated with critical actions?

   Yes, the list of stakeholders is appropriately comprehensive.

   Physicians are critical participants. Given widespread difficulties meeting the Meaningful Use Stage 2 interoperability requirements (in particular those associated with care transitions) and concerns regarding the value of the Standard Dataset, it is important that physicians see value in these proposals. ONC has received a substantial amount of criticism – it would be helpful to more meaningfully seek wider physician participation as tactical plans to accomplish these actions are developed.

   Given the critical role of data aggregation across providers in the context of population health management, Ochsner wonders if it is wise to postpone consideration of the intersection of clinical and administrative electronic health information. While we agree that what is really wanted is the clinical data at the present time, it is considerably simpler to obtain and integrate administrative (claims) data. If ONC agrees that a priority use case is the management of populations, then it needs to give further consideration to the role that payers as data sources should play and in what time frame. In our Accountable Care Organization and risk-based population management practices, access to patient data across disparate providers and EHRs is challenging. Absent ready access to clinical data, administrative data is nonetheless helpful.

   A majority of patient transitions to providers outside our own health system (and thus not on the same EHR platform) are for services we don't pervasively offer (nursing homes, home health, physical therapy) and to providers who are not participants in HITECH, do not have EHRs, and generally lack interest in receiving clinical information (and certainly not much of what is contained in a summary of care record) electronically. This gap is noted in the Roadmap but is an important problem that needs more attention than just voluntary certification. ONC might consider making some minimal electronic data management infrastructure a requirement of participation.

2. Priority Use Cases:

We suggest that Ochsner's priority use cases are the following:

1) Providers (and patients) have the ability to query data from other sources in support of care coordination (patient generated, other providers, etc.) regardless of geography or what network it resides in.

2) 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.

3) Patients have the ability to access their holistic longitudinal health record when and where needed (and for whatever purpose).

3. Governance:

How can ONC best recognize and support the industry-led governance effort?

Recognize the shortcomings of a model based on federated state-by-state health information technology plans and ONC-funded health information exchange (HIE) efforts. For the most part, we built the wrong infrastructure (data aggregation rather than connectivity), and we failed to focus on common agreed-to outcomes (state HIE use cases differ widely and few focused on infrastructure needed to enable Meaningful Use Stage 2 interoperability).

ONC/CMS should engage stakeholders to create the national interoperability framework and to define the guardrails. This process needs to lead to agreement on and clear articulation of the priority use cases.

4. Supportive Business, Cultural, Clinical and Regulatory:

Individuals:

In Ochsner's experience, the public is not well informed regarding their right to access health records and they express surprise when we, as healthcare providers, have no access to information regarding care they received elsewhere. Our patient portal, which offers selfservice appointments, secure messaging with their providers, and access to a substantial portion of their medical records nevertheless only provides access to information associated with services obtained at an Ochsner facility. An ONC/CMS campaign to raise public awareness would complement our and other providers' efforts to increase patient engagement.

Blue Button:

It would be most helpful if the Veterans Administration record system could be accessed through emerging technologies similar to those ONC seeks to leverage in this interoperability proposal. While it would be possible to seek VA records through eHealth Exchange, that avenue does not seem to be a part of this proposal. As healthcare providers in New Orleans, we know only too well how helpful access to veterans' records in adverse circumstances would have been. Providing care for veterans absent access to their electronic records continues to be a pain point for our providers.

Providers:

Ochsner Health System, a part of Ochsner Clinic Foundation

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We note that most of our physicians, intent on providing the best care for their patients and despite a major focus at Ochsner on Meaningful Use, are not familiar with the concept of "interoperability" or their role in an evolving healthcare ecosystem extending beyond our own practice. For the community physicians Ochsner interacts and shares patients with, that is certainly the case. It would be helpful if all physicians had more exposure to these concepts in their medical training and at meetings they attend. Noting that ONC has been very visible throughout the country this past year, we encourage your continued engagement with physicians wherever you may encounter them.

5. **Privacy and Security Protections for Health Information:**

Thank you for undertaking the effort to clarify privacy responsibilities. While 45 CFR 164.308(a)(1) makes components of a security risk assessment explicit, providing a standard risk assessment tool will be of benefit to a great many physician practices. Understanding that HIPAA enables interoperability rather than inhibits it, is important to reiterate and clarify. Ochsner has experienced increasing unauthorized efforts to access our systems from outside our firewalls and strongly supports renewed emphasis on cyber security and data encryption.

6. **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?

      Presently semantic standards permit Ochsner's EHR to consume medications, medication allergies, and problems electronically communicated to us from non-Ochsner providers. We note, however, that most vocabulary standards including LOINC, SNOMED, and portions of RxNorm (prescription Sig) are not applied with enough precision to enable their electronic reconciliation. In particular, we encourage ONC to continue to emphasize the importance of discrete data and to drive towards greater precision in their definition. At the same time, we applaud the inclusion of notes in the common clinical data set, enabling textual communication and preservation of the patient's story.

   2. Do you believe the approach proposed for Accurate Individual Data Matching will sufficiently address the industry needs and address current barriers?

      Given that a national patient identifier is not a near-term option, demographic matching is the most practical alternative. Key, however, will be clearly defined data content and format. Most data matching infrastructures are probabilistic, meaning that by definition there will be some mismatched data and some unmatched data. In Ochsner's environment, all inbound summary of care records from non-Epic sources require patient identity verification before we incorporate such data into any patient's chart. This process is overhead laden and injects a time delay before outside information is available at the point of care. Consistent application of demographic standards by all vendors should improve this situation and ultimately result in reliable electronic matching.

      A national provider Directory, as noted, is an essential enabler of exchange. Providers and provider facilities (nursing homes and the like) are uniquely identified in the National Plan and Provider Enumeration System (NPPES), and we agree with your proposal to leverage the NPPES to develop nationally known Direct addresses.

Considerations regarding Standards should include:

- Recognize the critical dependence on clinical documentation ("good" data, not necessarily "big" data). If it does not "tell the story" then downstream clinical communication and analytics are negatively impacted.
- EHR assembly of the required dataset must be coded to standards.
  - Make it easy for providers to annotate ("Notes/Narrative").
- Assure that the common dataset is semantically interoperable and that data format and packaging is absolutely standard.
- Transport mechanisms need to be clearly defined and ideally would evolve similar to e-prescribing, which took more than a decade to mature.
- Receiving systems must be able to consume and reconcile all of the elements of the common dataset.
- Vendors must be required to "plug and play" at no additional cost to providers.
- Assure vendor adherence by meaningful, detailed, and stringent certification
- Be careful about emerging technologies, no matter how compelling (e.g. FHIR)

7. Certification and Testing:

In what way can semantic interoperability be best tested?

Our legacy in-house developed EHR was certified by the pre-HITECH Certification Commission for Healthcare Technology. That process, while arduous, required the execution of a limited number of scripts that checked for limited semantic coherence. The process today requires vendors to ensure that their products execute required scripts but again the scope of testing is limited and execution in the provider's environment may yield substantially different results.

While interoperability "connectathons" such as the HIMSS Interoperability Showcase are useful demonstrations of interoperability they also are limited in their scope and are not adequate to ensure the useful and accurate receipt and consumption of clinical data in the real world. While evolving FHIR-API intermediated exchange may improve interoperability between vendors, we suggest that more care be taken with vocabulary maintenance, robust semantic standards, and test scripts that are more widely representative of real world exchange. Much as the CMS FAQ postings have informed Meaningful Use, we suggest you consider a NIST FAQ website to improve and clarify unclear or missed details in test scripts. Easy access to updated information would enable Certification proctors to test vendor software to the same level of detail and for the same functionality more consistently.

8. Measurement:

We agree with your proposals. Many relevant measures are derivative of clinical documentation, including many Quality Metrics. Taking care to ensure that metrics in fact reflect the processes they are intended to assess is a critical component of measure development. Ochsner's 1000 plus provider group exhibits considerable variation in documentation, which variation is reflected in metrics extracted

electronically from our EHR. Understanding the processes such metrics are intended to reflect is confounded by provider documentation proclivities. We suggest that a limited number of metrics be developed to reflect progress with interoperability actions, that they be clearly defined in terms of process, vocabulary, format, or other relevant attributes, and that they be included in the certification process so that they will be uniformly applied across all vendor platforms.

Again, we would like to thank ONC for the work they have done surrounding the Roadmap. We hope that Ochsner can serve as a resource as you continue your important efforts.

Sincerely,

Lynn R. Witherspoon, MD
Chief Medical Information Officer
Ochsner Health System