**Oregon Health Authority’s comments on**

**ONC’s 2015 Interoperability Standards Advisory**

May 1, 2015

**General Comment Summary:**

Overall, the Oregon Health Authority’s Office of Health Information Technology finds the 2015 Interoperability Standards Advisory to be a useful tool and companion to the Interoperability Roadmap. It will serve as a helpful list for the industry and those working to further interoperability to move toward this shared vision.

We also agree with the interactive process and the annual update of the Advisory. We agree with ONC that this will ensure a list of standards and implementation specifications for a broad range of clinical health IT interoperability purposes, and allow the specifications to remain nimble and responsive to developments in the field of health IT. We also look forward to the discussions and debates around standards and implementation specifics, believing that an open dialogue between stakeholders, including both members of the technical industry and the utilizers of the systems will ensure an ever-improving system that assists in the ultimate end goal—a more responsive health care system that sees increased patient engagement and improved patient outcomes.

As the 2015 Advisory is executed and the summarily updated for 2016, it will be important for ONC to coordinate and collaborate with key stakeholders beyond vendors and including states, private providers, health plans, and others with a vested interest in health information technology interoperability on the efficacy and real world application of the standards. It will also be critical for ONC to facilitate greater transparency on the functionality that vendors possess. This will assist stakeholders in identifying appropriate vendors that most closely fit their needs.

We appreciate ONC’s recognition of the healthcare provider directory (HPD) standard for provider directories.   One of the current health information technology projects in Oregon is the development of statewide provider directory services, with federal investment through CMS support.   Provider directory services (PDS) will allow healthcare entities access to a state-level directory of healthcare provider and practice setting information.  The project goal is to establish an accurate source of key health care provider information that can be shared across organizational boundaries. We intend to leverage existing data sources including the planned mandatory common credentialing database in Oregon and provider directories that comply with new standards for HPD and are engaging stakeholders now to understand the availability of the standard in the market and the value of incorporating the standard. We believe this to be fully in line with the 2015 Standards and are excited to see how the work ongoing in Oregon dovetails with the national level thinking.

We appreciate the inclusion of the QRDA I and QRDA III standards. As we invest in a clinical quality metrics registry (CQMR) in Oregon, we aim to leverage the QRDA in order to minimize administrative burden and ensure standardized data for quality metrics. This is an area where attention is needed to ensure that the real-world application of QRDA meets the promise of the value that it could bring. We support the forward motion on this effort and are pleased to see it is in line with the investments we are making in Oregon. We look forward to working with ONC to ensure real-world interoperability through QRDA, as this is a high priority for Oregon.

We appreciate seeing the standards on Direct secure messaging. The state of Oregon has made considerable investments to coordinate and enable statewide Direct secure messaging.  Challenges to this statewide effort have included varying applications of transport standards and implementation specifications by vendors.  As an EHNAC/DTAAP accredited DirectTrust member, we support the recommendations from the DirectTrust, as cited in their *A Report on Direct Trust Interoperability Testing and Recommendations to Improve Direct Exchange,* including: 1) revising and making improvements to the Applicability Statement and, 2) ensuring certification that will test real world capabilities.

We commend the continued use of HL7 v2 ADT messaging as an ONC-recognized standard. Oregon has invested in a system, called the Emergency Department Information Exchange (EDIE), which collects ADT feeds from hospitals in the state and provides utilization alerts back when a patient is triggered as a high utilizer of ED or hospital services. This system provides the infrastructure for pushing notifications to hospitals and providers. The continued interoperability of ADT is critical to the functioning of this system moving forward.

We believe that there is space within the Standards Advisory to further clarify how national and local requirements can be reconciled, and to provide additional guidance to vendors for ensuring that they build infrastructure and functionality that can meet or exceed these guidelines.  There are times when the national specification declares something as optional, but a state specification requires it. On occasion, the state receives push back from vendors in regards to state specific/national optional standards, as vendors often only build the national required functionality. We would encourage the ONC to facilitate or provide a forum for States’ laws and practices to be shared and discussed with vendors.

We appreciate and commend the recent federal efforts to provide clear and timely plans to advance HIT across the country. We will continue to look to HHS and ONC for HIT plans and guidance to ensure continually aligned efforts in Oregon.

**About the Oregon Health Authority’s Office of Health Information Technology:**

The Oregon Health Authority’s Office of Health Information Technology (OHIT) was established in 2011 as a part of the state’s health agency to support the adoption of electronic health records, the secure exchange of health information, and supporting meaningful use initiatives in the state. OHIT is a resource for both state programs and other public and private users of health information, providing planning, coordination, policy analysis and the development of public/private partnerships to further health IT in Oregon. Health IT is a key part of Oregon’s efforts to create a system of better health, better care and lower cost for all Oregonians.

**Specific Comments:**

| **Page** | **Section** | | **Phrase/paragraph from Plan** | **Comment/Recommendation** |
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| **2** | **Scope** | …this advisory focus explicitly on clinical health IT systems’ interoperability and will not include administrative/payment oriented interoperability | | We understand why the scope focuses on clinical health IT systems’ interoperability, however, there might be cases in which treatment, payment, and operations interoperability are tied together. It would be helpful to provide some direction on the appropriate standards for those instances, or to see a follow on document that addresses these concerns. |
| **6** | **Structure of sections I through IV** | The standards and associated implementation specifications for clinical health information are grouped into four categories… | | We appreciate the grouping of the standards and associated implementation specifications for clinical health information into four categories. It could be helpful to delineate the standards and specifications listed into the four proposed areas. This could denote the category that each document belongs to, assisting the reader with consumption of the information. |
| **8** | **II** | | HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2 | We support consolidation of CDA templates (one implementation guide) that results in 1) improved transparency of certified technology and their testing results, and 2) requirements on vendors for standardized formatting of clinical documents and header constraints to streamline exchange and ingestion of CDAs. |
| **8** | **II** | | Admit Discharge Transfer HL7 2x ADT | We commend the continued use of HL7 v2 ADT messaging as an ONC-recognized standard. The wide adoption of this basic standard has been critical to the development of “utilization alerts”—systems that process ADT information into clinically relevant alerts about emergency department and hospital event information. |
| **8** | **II** | Clinical decision support services | | The Decision Support Service aligns well with the emphasis on shared decision-making within the coordinated care model. Patient-specific assessments and recommendations will be helpful for care coordination purposes (assuming information can be shared across providers). |
| **8** | **II** | Clinical decision support – reference information | | The Infobutton standard will likely improve quality of care and support shared decision making at the point of care. Would the Infobutton information get stored in the EHR? To what degree can other providers within the network access that information for treatment purposes? |
| **9** | **II** | | Summary of Care: Consolidated CDA Release 2.0 | * We support a single source for implementers to find CDA templates that encourages the reduction of technology versioning, and rather fosters standardization and interoperability. * We encourage the ONC to take into consideration the challenges and solutions recommended by the DirectTrust in Chapter 2, Chapter 7 and Chapter 8 of the white paper *A Report on Direct Trust Interoperability Testing and Recommendations to Improve Direct Exchange,* found at[*http://static1.1.sqspcdn.com/static/f/1340919/26054983/1426686689687/Report+on+DirectTrust+Interoperability+Testing.pdf?token=A0DNBiAqjJ2YzuhUTn4vnBMrtVI%3D*](http://static1.1.sqspcdn.com/static/f/1340919/26054983/1426686689687/Report+on+DirectTrust+Interoperability+Testing.pdf?token=A0DNBiAqjJ2YzuhUTn4vnBMrtVI%3D) * The State of Oregon’s CareAccord program (EHNAC/DTAAP accredited health information service provider (HISP)) has seen many challenges with Direct secure messaging exchange of CDAs. Instead of a fluid exchange (export of a CDA from one EHR to the ingestion of a CDA by a different EHR), there are numerous issues due to different versioning, header issues, and document formatting. Some CDAs are ingested but when printed they are 50 pages long, others are rejected when the EHR tries to ingest them. This results in many hours between HISPs, EHR vendors and Providers problem solving each new partner exchange to solve interoperability issues for a successful exchange. |
| **9** | **II** | | Quality Reporting (aggregate) | We support this standard. |
| **9** | **II** | | Quality Reporting (individual) | We support this standard. |
| **9** | **II** | | Segmentation of sensitive information | The CDA is an important tool for the exchange of health information among providers and to appropriately coordinate care for patients. Does the “standard” link to CDA Release 2 include the various data elements that should be included in a CDA? If not, it would be helpful to provide a link to this information. |
| **10** | **IV** | | An unsolicited “push” of clinical health information to a known destination | * We support the expanded guidance (in the 6/25/2014 Version 1.1) of the Direct Edge Protocols which includes IMAP4 and POP3 Edge Protocols, not limiting it to only IHE XDR and SMTP. Additional delivery methods support greater interoperability when specifications in the Edge Protocol are followed by HISPs and Edge systems. * We encourage the ONC to take into consideration the recommendations and solutions put forward by the DirectTrust in the white paper *A Report on Direct Trust Interoperability Testing and Recommendations to Improve Direct Exchange*, found at <http://static1.1.sqspcdn.com/static/f/1340919/26054983/1426686689687/Report+on+DirectTrust+Interoperability+Testing.pdf?token=A0DNBiAqjJ2YzuhUTn4vnBMrtVI%3D>. * Delivery Notification Tracking (MDNs) should be a required standard, with specifications added to the *Applicability Statement,* to ensure than Direct secure messages containing potentially critical patient PHI does make it all the way to its end receiver’s Direct messaging inbox; and to ensure that if the message is not delivered, that the sender is accurately notified * The State of Oregon’s CareAccord program (EHNAC/DTAAP accredited HISP) has encountered challenges with Direct secure messaging exchange related to vendor interpretation and implementation of the current standards and specifications. Some examples include:   + SMTP/SMIM and SOAP/XDR - Some Direct users may only send/receive Direct secure messages that include a CCDA attachment. This means they can only receive a Direct secure message from an EHR Direct user – not a web-portal user; they are unable to send a Direct secure message back requesting clarification on a CCDA; they cannot attach any other document (x-ray, echocardiogram, etc.) in their Direct secure message. Simple back and forth exchange is rendered virtually impossible. In some cases a Direct secure message sent without a CCDA attached may be dropped or not delivered in transit, and the sender may not know that it has not made it to the final destination * Send and Receive Limitations - XDR standards require that CCDAs be in .zip format when sent via Direct. Some EHRs using SMTP can’t receive and/or open and ingest .zip format |
| **11** | **IV** | | **Provider Directory** | We support this standard. There has historically been some inconsistency in the version names and we are under the assumption that was is being referred to is this standard: <http://www.ihe.net/uploadedFiles/Documents/ITI/IHE_ITI_Suppl_HPD.pdf> |
| **11** | **V** | | **5-1** [Section 1] | We would like to see laboratory results – and recommend SNOMED CT  We would also like to see the addition of specimen type – and recommend SNOMED CT; addition of specimen source – and recommend SNOMED CT; and addition of diagnosis/reason for study – and recommend ICD-10. |
| **11** | **V** | | 5-5 [Section 1] | We believe it would be helpful to have language around how state specific specifications must conform to the national recommendations whenever possible. There are instances where a national specification declares something as optional, but a state specification requires it.  There could be value in specifying concepts that are called out elsewhere, but also place them in a document like this that can be easily referenced (e.g., calling out the differences between required, required but may be empty, optional, and unsupported). |
| **12** | **V** | | 5-7 [Section 1] | We believe that ICD-10 should remain in this advisory |
| **12** | **V** | | 5-10 [Section 1] | We believe that MVX should be included and listed in tandem with CVX |
| **12** | **V** | | 5-11 [Section 1] | We believe that use of NDC codes should be called out for administered vaccines, and should be differentiated from historical vaccines |
| **12** | **V** | | 5-12, 5-13 [Section 1] | We think that, if unable to identify a single code set, recommend NHSN Occupation Codes for health care workers |
| **12** | **V** | | 5-14 [Section II] | We would advise that rather than recommending something that hasn’t been vetted, the Advisory should propose a review/comment of any newly available standards as they come out. |