The Office of the National Coordinator for Health Information Technology

Meeting Notes

INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE (ICAD TF)

September 15, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Sheryl Turney and **Alix Goss,** co-chairs, welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. **Sheryl** reviewed the agenda for the current meeting and provided an overview of the activities of the previous meeting. Then, **Sheryl** presented the major themes and feedback the HITAC provided following the ICAD TF co-chairs' presentation at the September 9, 2020 meeting. TF members and the co-chairs discussed the presentation to the HITAC and resulting feedback. **Alix** facilitated the ICAD TF's discussion of the broader intersection of clinical and administrative data, and TF members held a robust discussion. Finally, the co-chairs briefly reviewed the TF's plans for moving forward and the next steps. There were no public comments submitted by phone. There were several comments submitted via chat in Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	Summary and Action Plan
03:10 p.m.	Discuss HITAC Meeting and Feedback
03:20 p.m.	Broader Intersection of Clinical and Administrative Data
04:20 p.m.	Public Comment
04:25 p.m.	Next Steps
04:30 p.m.	Adjourn

CALL TO ORDER/ ROLL CALL AND WELCOME

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the September 15, 2020, meeting of the ICAD to order at 3:02 p.m. ET.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Steven Brown, U.S. Department of Veterans Affairs
Gus Geraci, Individual
Anil K. Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Jocelyn Keegan, Point-of-Care Partners
Rich Landen, Individual/NCVHS
Arien Malec, Change Healthcare
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Ram Sriram, National Institute of Standards and Technology
Sasha TerMaat, Epic
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Mary Greene, Centers for Medicare & Medicaid Services
Thomas Mason, Office of the National Coordinator
Jacki Monson, Sutter Health/NCVHS
Alex Mugge, Centers for Medicare & Medicaid Services
Alexis Snyder, Individual/Patient Rep
Debra Strickland, Conduent/NCVHS
Andrew Truscott, Accenture

SUMMARY AND ACTION PLAN

Sheryl Turney and **Alix Goss,** co-chairs, welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. Then, **Sheryl** reviewed the agenda for the current meeting and provided an overview of the activities of the previous meeting, during which the ICAD TF reviewed comments on the last few recommendations, made edits, and discussed moving forward. The TF had a rich discussion of the broader intersection of clinical and administrative data, including themes related to workflow integration, the importance of patient centeredness, transparency, and support for workflows across the care continuum. She explained that the discussion would continue at the current meeting.

DISCUSS HITAC MEETING AND FEEDBACK

Sheryl Turney presented the feedback the HITAC provided following the presentation the ICAD TF co-chairs gave at the September 9, 2020 meeting. Some of the major themes included:

- Recognition of extensive work to date and enthusiastic support
- Guiding Principles to recommendations correlation needs to be explicit
- Increased specificity of recommendations
- More focus on patient and caregiver involvement and engagement
- Price transparency for patients to compare prices on the open market

Sheryl noted that the feedback from the HITAC was energetic and helpful and expanded on several of the major themes while sharing information related to her personal experiences. She noted that the TF should address these themes, whether or not they can be dealt with by the TF. Some other topics included the convergence and harmonization of standards, piloting, the standard promotion model, administrative data and the United States Core Data for Interoperability (USCDI), patient burdens and the patient engagement journey.

Also, **Sheryl** noted that many questions were submitted related to the release of the ICAD TF's final version of the paper. Some health care partners asked for another opportunity to weigh in on the paper before it is finalized and passed on to ONC, but **Sheryl** explained that this would go against protocol. The TF will continue to present and comment on sections of the paper within the public forum of their meetings and edit the paper with the entire TF present. She asked any interested parties or those that have additional comments participate in the TF's weekly meetings, submit a statement during the open period for public comment, or submit written comments to the TF. The editors of the TF's paper have been cross-checking the Guiding Principles, Ideal State, and Recommendations sections against comments submitted by healthcare partners.

Discussion:

- **Arien Malec** commented that, at the ICAD TF's presentation to the HITAC, many of the comments submitted were positive, and there was a high level of enthusiasm and interest in participating in the draft document. He noted that there will be multiple opportunities for interested parties to comment on the document through the several public comment mechanisms, which the TF encourages the public to use. All materials will be made available publicly before approval by the full HITAC. This response is emblematic of the importance of the TF's work within the US healthcare system.
- **Alix Goss** commented that the ICAD TF is a task force of the HITAC, so there are rules and protocols that must be respected. She noted her appreciation for the transparent process the TF has taken and explained that all comments and submissions are being cross-checked as the TF works on the document and continues the discussion of the broader intersection. She noted that ONC has contracted with an editor to assist the TF and ONC with the report document. She encouraged TF members to engage with the draft document and to provide feedback to give the industry reviewers fully a complete picture of the TF's work.

- **Sheryl Turney** thanked the ICAD TF members for their work and reminded them that the plan is to submit the final draft of the TF's report by October 15 in time for the HITAC's October 21, 2020 meeting.
- **Alix Goss** also thanked all TF members and those who provided public comments and noted that the HITAC gave the TF many compliments on their work.

BROADER INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA

Alix Goss began the ICAD TF's discussion of the broader intersection of clinical and administrative data by displaying and describing a document that listed the major themes from the TF's previous conversation on the broader intersection of clinical and administrative data, including comments from the HITAC. She explained that she would lead the recap and following discussion and encouraged the TF to think more holistically about the ecosystem and convergences of the different frameworks for governing clinical and administrative data. The document will be updated during the TF's to capture any additional themes, principles, and notes submitted to evolve the report's content and inform the development of recommendations. **Alix** thanked **Sheryl Turney** and **Michael Wittie** for their initial work on the document and reminded TF members that they could raise their hands in the meeting software to submit a comment.

The overall themes and general notes on from the ICAD TF's previous discussion on the intersection of clinical and administrative data included:

- Overall Principle: No portals – all within natural workflow of a given stakeholder.
- A converged ecosystem has to include additional actors, including public health, vital records, research, and policymaking:
  - Goal of creating an environment that is also supportive of public health and vital records without creating burden or new provider data capture activities.
  - Use beyond clinical (re-use of data):
    - Labs, public health, registries, etc. can add burden to providers but value is ever more apparent in an emergency situation, but data has to be reconciled and integrated from different sources. Labs may report the same event using different codes, etc., than a clinician's office or health information exchange (HIE).
    - Research uses different data (and uses it differently).
    - Vital records could also be connected – though some states have restrictions on how bidirectional that can be.
    - Capturing and exchanging data across all these functions seamlessly will require consistency, and that has real potential to reduce burden – record once and re-use. This leads to the USCDI discussion, below:
      - A minimum data set that allows a refined way of looking at an aligned clinical-administrative picture for these "downstream" stakeholders to see what they can do as a baseline that may need to be expanded later (but again, not based on additional data collection by clinical providers).

Discussion:

- **Sheryl Turney** commented on concerns over data sharing related to clinical data being used for secondary or other purposes than the original intent. Also, she discussed the concerns around providing only the minimum necessary information for data exchange requests and the re-use of that data for other purposes. She noted that the ICAD TF should discuss the potential framework the TF could recommend, given the context of interoperability rules. She suggested that, given the TF's recent discussions around public health and lab reporting, data sharing should be limited unless the patient gives authorization.

- **Steve Brown** noted that the ICAD TF had discussed terminology standardization but, as a group, has not considered standardizing the process of patient observation. He discussed elements involved in the observation of a patient and noted that terminology a provider enters about a patient's condition(s) (or lack thereof) is not standardized. He stated that the way that the terminology payload is delivered and the appropriate context needs to be looked at and standardized.
  - **Alix Goss** requested that **Steve** repeat and clarify his explanation and asked if he recommended a new recommendation or an activity for the TF.
  - **Steve** responded that the TF not only needs to consider organizational concepts like consent, terminology, and standards but also should review the elements of a statement model.
  - **Sheryl Turney** asked **Steve** if he was describing the situation that occurs when the full clinical record is sent for interpretation and some of which is only useful and applicable that one time.
  - **Steve** responded that to record data once and re-use it that there must be standards in place for how the data are represented. Standards are also needed to represent information from a provider's observation of a patient, and small information models exist that address metadata from a patient observation.
  - **Alix** responded that TF members had reported audio quality issues. She asked **Steve** how his topic tracks the provenance of the data.
  - **Steve** responded that the provenance would be included in the metadata related to an observation, and, if this metadata is not standardized, it is difficult to re-use this data.
  - **Alix** noted that she included Steve's comments in the draft document.
- **Anil Jain** submitted several comments:
  - The TF has to separate the secondary use of data as provisioned by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and alternate/additional uses that were not contemplated when the data was collected.
  - **Steve's** point was that metadata helps show how information was collected, but it also creates layers of complications. The first step is to make sure that all of the details are entered when making patient observations.
  - The problem is that standards for secondary data are being used in the industry in various ways, so best practices and guardrails need to be established around existing standards before the focus shifts to standardizing metadata.
  - **Steve Brown** noted his agreement but stated that even if this is done correctly, it could fail.
  - **Anil** discussed the example of two different machines with different ranges for "normal" producing blood test results and noted the machine that ran the test should be linked to the data. He cautioned that when more information is attached to data payloads, they become too complicated to allow for possible uses of secondary data.
- **Jocelyn Keegan** noted that **Steve's** comments were legitimate and would be part of the maturing process of using standards. She submitted several comments on the potential recommendations the ICAD TF could make, including:
  - The TF should be clear about choosing and defining standards value sets that will be used to create a minimum bar for compliance.
  - Each standards organization treats getting to the semantic interoperability that **Steve** referenced in very different ways.
  - She discussed the use of Fast Healthcare Interoperability Resources (FHIR) at the application programming interface (API) level and implementation guides. She also discussed her experience of creating example sets with the Da Vinci Project that depict interactions in implementation guides.

- The tools have to be used to grow and mature, and the caution around full automation when the data that is being used might be imperfect. There are tools available across the different standard sets to achieve the points **Steve** discussed, but the TF should make sure that whatever is rolled out is useable in the current world, rather than an ideal state that does not exist.

- **Arien Malec** submitted several comments, including:
  - Privacy and Security is, by design, a foundational part of the TF's Guiding Principles and Recommendations but should also be called out within the preamble or executive summary/stage setting section of the report.
  - He discussed information models, noting that they are a good thing, but cautioned the TF against waiting for the perfect information model to be developed before standardizing electronic prior authorization (ePA). There is value in getting ePA data flowing, even if an information model does not back it, and this process can be refined in the future. The TF should reiterate that information models are important and should unify recommendations under the PA section in the report.
  - **Steve Brown** noted within the chat feature in Adobe that he included additional information on the work in HL7 on Analysis Normal Form (ANF). In response to a request from **Alix Goss** that all TF members frame comments as specific suggestions for the final report to the HITAC, he suggested that the TF include the recommendation that small information models (beyond terminologies) and statement models are needed and should be incrementally adopted to advance interoperability.
  - **Alix** noted that **Steve's** recommendations are already included within the TF's recommendations and discussed how the HITAC and ONC would use the TF's recommendations. However, **Steve** suggested that this slightly different view of the situation should be captured and that standards need to be enhanced by additional analysis work. They discussed their opinions, and **Alix** captured the recommendation in the shared document.
- **Anil Jain** voiced his agreement with **Steve's** comments and discussed his perspective on the topic, informed by his experience practicing in a clinical setting. He submitted several comments, including:
  - If the TF recommends collecting information in a way that information models can represent, burden could accidentally be added to the clinical setting, which is already overburdened.
  - The TF could make a recommendation that information models should be done in stages to align clinical and administrative data for secondary use in stages based on the highest societal priorities. Examples of current priorities would include supporting public health topics like infectious diseases or emerging pathogens.
  - **Steve Brown** suggested that he did not mean to create additional burden for providers through this suggestion.
  - **Anil** responded that the burden of standardization on the back end often affects the front end, which places additional burden on providers. As an example, he discussed how ICD-10 helps downstream data, public health, and billing but creates burdens for clinicians. He recommended moving towards the direction **Steve** suggested while giving tangible, important/relevant areas where the community can build information models.

Alix Goss continued to provide an overview of the main themes from the ICAD TF's previous discussion, which included:

- Supporting care specialty and long-term care delivery data flows (transitions of care, handoffs, etc.)
  - Need to explore how to create a system where data available to providers can make it available to others on the care continuum (and those who may not have all the same "tools" in which to receive/process – which is addressed below)
  - Ideally, information should be available in the system that the relevant actor normally uses in regular workflow (e.g., electronic health record (EHR) for provider, management for practice staff, claims for payors, ideally a single portal or point of access for patients).
    - This could include addressing gaps in care, for instance, tracking when a referral was missed or prescription not filled – whatever the reason, multiple parties may have an interest in following up/making sure that the patient's needs are met.

Discussion:

- **Alix Goss** discussed the themes and asked if ICAD TF members would like to comment on the continuum of data flow consideration and dynamics that occur with specialty care or long-term care environments and the porting of data.
- **Anil Jain** noted that this is something he deals with daily as a clinician and discussed the variability of metrics by which care gaps are identified and measured. He suggested that the rules used to identify these metrics could be shared and noted that the clinician/physician, the plan, and the patient have different roles within the ecosystem. He suggested that there might be disagreements of true care gaps when the clinical and administrative data begin to harmonize.
  - **Alix Goss** discussed how to best capture **Anil's** points with him and noted opportunities to work them into the existing Recommendations and Guiding Principles.
  - **Anil** suggested that the following two items be added to the shared document:
    - There is a concern with gaps in care and challenges that exist.
    - Keep patient at the center in the care gaps scenario, with a harmonized understanding of their healthcare.
  - **Sheryl Turney** noted that **Anil's** recommendation to focus on the rules for the care rules is more helpful than focusing on the gaps themselves and suggested that communicating the rules for care gaps would be helpful to clinicians. She stated that care gaps come from multiple places like the quality of care and legislative and state-mandated measures.
  - **Anil** discussed the example of a patient with chronic conditions being asked to do a colonoscopy, though they should not have one due to their current conditions/medications, as an example of how data could become misaligned, which would lead to patient confusion. There are unintended consequences when more data are shared.
  - **Alix** thanked **Sheryl** for her clarifying comments and continued to discuss **Anil's** example of the patient who is notified of the need for a colonoscopy as an example of how gaps in care can be communicated to the patient and dealt with by the care providers.
  - **Anil** commented that, in the ideal situation, there are rules for identifying gaps in care if they are known to all parties. In the situation that is not ideal, the patient could be left wondering which care provider has the best advice/information. He suggested a need to find ways to exchange information based on the data needs in a world with diverse opinions on care treatment and gaps.
  - **Sheryl** and **Alix** thanked Anil for his clarifying comments.

Alix Goss continued to provide an overview of the main themes from the ICAD TF's previous discussion, which included:

- Have and have-not's onramp – as data are exchanged with players at all levels of maturity, it must be possible to integrate data at the individual patient level.
  - It will be important to start with identifying the system (e.g., API) needs for common interactions, and then expand – develop a base template with an eye towards it being reusable and extensible. Not everyone is on FHIR yet, but many are moving in that direction by common conceptual frameworks (e.g., data sets and templates) moves in the right direction – and that incentivizes, somehow, moving from step 1 to step 2, etc.
- USCDI administrative data:
  - What data concepts and elements have to be reflected in the USCDI for administrative data to achieve integrations?
  - Need a review of current administrative transactions and associated value/code sets to ensure USCDI supports downstream clinical and administrative functions.

Discussion:

- **Alix Goss** reviewed the themes and suggested that the final bullet point under USCDI administrative data be turned into a recommendation for the ICAD TF's report. No other TF members submitted comments.

Alix Goss provided an overview of some new themes that the ICAD TF could consider in their discussion of the broader intersection, which included:

- Synthetic data and testing:
  - Adding admin and transaction data to Synthea, for example, or to AGIS testing mechanisms
  - A recommendation should include an ecosystem with built-in players, synthetic data, and testers to make sure it all works properly.

Discussion:

- **Alix Goss** reviewed the themes and noted that, historically, there had not been testing or the synthetic data to support testing in the ecosystem for the administrative side. She discussed NCVHS's struggles with complying with requests to upgrade a standard vocabulary or transaction standard. She explained that there are some tools in the ecosystem (Synthea, AGIS testing) but highlighted the need for the recommendation.
- **Ram Sriram** submitted a comment in the Adobe chat that asked what the process is for verification or validation? He noted in the chat that he was not able to connect to the meeting audio, so **Alix Goss** suggested that he submit further comments in writing or within the text of the ICAD TF's shared document.
- **Sheryl Turney** discussed similarities between synthetic data, testing, and piloting programs. She noted that, in her experience using synthetic data in piloting projects, the various connections between the synthetic data create challenges.

Lauren Richie opened the meeting for public comment.

PUBLIC COMMENT

There were no public comments via the phone.

Questions and Comments Received via Adobe Connect

Lauren Richie: we will get started shortly

Rich Landen: yes

Rich Landen: Agree with the no portal goal

Jocelyn Keegan: Jocelyn Keegan, here, apologies for tardiness, meeting conflict.

Lauren Richie: welcome Jocelyn

Jocelyn Keegan: Steve keeps going under water :)

Jocelyn Keegan: I can

Jocelyn Keegan: but defer to the guys

Sheryl Turney: i was kicked out of the speaker module and have come back in but was put int he *[sic]* public

Sheryl Turney: so I can't see hand raising, etc.

steven brown: https://www.hl7.org/implement/standards/product_brief.cfm?product_id=523

steven brown: Analysis Normal Form (ANF) is a logical model intended to represent a normalized view of aggregate clinical statements for analysis, research, clinical decision support, and other purposes. ANF can be used to represent any clinical statement irrespective of how the information was captured at its source The ANF Reference Model and methodology can be used in conjunction with other models intended to ensure that clinical information is structured and complete at the time of entry (e.g. CIMI models, ISO/TS 13972 Detailed Clinical Models) or exchanged among systems (e.g. HL7 CDA templates, HL7 V2 message profiles, FHIR profiles).

Lauren Richie: For those members of the public, we will take comments shortly.

Lauren Richie: To make a comment please call: 1-877-407-7192 (once connected, press "*1" to speak)

Ram D. Sriram: What is the process you wil *[sic]* have in place for verification and validation?

Ram D. Sriram: Thanks, but I am not able to connect via audo. *[sic]*

G: Thanks!.

Following the public comment period, the ICAD TF co-chairs continued the discussion of the major themes.

Discussion:

- **Ram Sriram** commented that if there is an ecosystem, there should be mechanisms and protocols for testing the ecosystem. He asked if it already exists.
  - **Alix Goss** responded that this is a blank slate, and the ICAD TF should discuss how to thoughtfully recommend an ecosystem that can meet future testing needs.
  - **Ram** volunteered to work on this topic.
  - **Alix** noted that if clinical and administrative data are brought together, an ecosystem will be needed and end-to-end testing mechanisms and a platform. She suggested that the TF make a recommendation that something is created but not specify how or who will do it.

- **Jocelyn Keegan** commented that there are commercial opportunities that consider themselves sandboxes for validation and testing for tool vendors and for-profit and non-profit entities. The ICAD TF should take stock of what is happening in this market, and she listed several Da Vinci Project members who are working with accelerators who are providing sandboxes for work related to implementation, testing, FHIR, etc. She suggested that the TF look at the base minimum set of test data across datasets and standards needs to be, who needs to fund that work and then make sure that it is available. She emphasized that there is unequal access, depending on how much capital someone has to bring to this type of innovation work. There are commercial market aspects to consider in meeting the need for minimum testing, and she suggested that the federal government can help to create a floor for this aspect.
    - **Alix Goss** stated that **Jocelyn's** discussion points could lead to a recommendation for the federal government to help provide oversight and orchestrate resources.
    - **Jocelyn** responded that it is worth calling out that the FHIR ecosystem advancements for piloting and testing. Specifically, ONC's FAST group is looking at this but is not focused on the intersection of clinical and administrative data. She and **Alix** discussed their experiences with burdens and challenges connected to related efforts.

NEXT STEPS

Alix Goss provided an overview of the next steps and explained that, at their next meeting, the ICAD TF will reconcile all final TF comments and will continue to focus on the broader intersection conversation. She noted that ONC has retained an editor/writer to assist the TF with their final report document and thanked **Arien Malec** and **Rich Landen** for their work on the Recommendations section of the document. She described the offline work, during which all TF members are encouraged to review the contents of the document and submit comments by the end of the day on Friday, September 18. Finally, the co-chairs will deliver the final recommendations and report to the HITAC on October 21, 2020.

ADJOURN

Sheryl Turney and **Alix Goss** thanked everyone for their participation and reminded them that the next meeting of the ICAD TF was scheduled for 3:00 p.m. ET on September 22, 2020.

The meeting was adjourned at 4:29 p.m. ET.