Collaboration of the Health IT Policy and Standards Committees

Final Summary of the June 23, 2016, Joint Meeting

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator for Health Information Technology (ONC), welcomed participants to the Health Information Technology Policy Committee (HITPC) and Health Information Technology Standards Committee (HITSC) joint meeting. She reminded the group that it was a Federal Advisory Committee Act (FACA) meeting being conducted with two opportunities for public comment (limited to 3 minutes per person) and that a transcript will be posted on the ONC website. Members introduced themselves. Consolazio told members to identify themselves for the transcript before speaking. New members were recognized: Larry Wolf, Strategic Health Network; Aaron Miri, Imprivata; Peter Johnson, Dartmouth-Hitchcock; and Terrence O'Malley, Partners HealthCare. Wanmei Ou, Oracle, was introduced when she arrived later. Several new members were absent and will be introduced at the next meeting. Members Cris Ross, Elizabeth Johnson, John Derr, and Wes Rishel are rotating off the HITSC now that their replacements have been appointed.

Review of Agenda

HITPC Co-chairperson Paul Tang asked for a motion to accept the summary of the June 8, 2016, meeting as circulated with the meeting materials. A motion was made and seconded. HITPC Co-chairperson Kathleen Blake requested a correction under the discussion of the Quality Payment Program (QPP) Task Force report. She said that her comments on the Core Quality Measures Collaborative and the American Medical Association had been incorrectly summarized. Tang told her to submit a correction in writing to staff for incorporation into the summary. He noted that he, too, had submitted a correction. The summary as corrected was approved unanimously by voice vote.

> **Action item #1: The summary of the June 6, 2016, joint meeting as corrected by Blake was approved unanimously by voice vote.**

Office of the Chief Privacy Officer Updates

Lucia Savage, ONC, reported on the Cybersecurity Information Sharing Act of 2015, which requires that the U.S. Department of Health and Human Services (HHS) report on the preparedness of health care industry stakeholders in responding to cybersecurity threats. The secretary is required, in consultation with the Director of the National Institute of Standards and Technology (NIST) and the U.S. Secretary of Homeland Security, to convene a Threat Sharing Task Force and a Security Standards Task Force. U.S. Secretary of Defense Ash Carter reportedly said that he was impressed by the Hack the Pentagon program, in which more than 1,400 hackers signed up for the bug bounty pilot initiative targeting Pentagon websites, with more than 80 bugs discovered that qualified for payouts so far. Savage said that she wondered how ethical hacking could help security in the health care sector. She indicated that ONC staff are working on the application of this process in health care.

Savage reported that staff members are working on fact sheets on the application of 45 CFR 164.512 to public health activities and the use and disclosure of protected health information. Work is also being

done on health oversight and to explain the basic choice of opting in or out. For information on the Health Care Industry Cybersecurity Task Force, visit http://www.phe.gov/preparedness/planning/CyberTF/Pages/default.aspx. Meeting materials from the first public meeting are available at http://www.phe.gov/Preparedness/planning/cip/Pages/HCICTaskforce.aspx. The second public meeting is July 21, 2016. There will be opportunity for public comment. The agenda and materials are not posted yet.

Q&A

Blake talked about hacking medical devices. The National Medical Device Evaluation System is developing a public-private partnership to evaluate the safety and effectiveness of devices, not just at the time that they are proved but also going forward as they are used on patients for many years. Blake described two opportunities for safely hacking medical devices; one is at the time of implantation, and the second is at the time of replacement. Dale Nordenberg is working on these methods. Savage responded that although medical devices are not within ONC's purview, she will follow up on the suggestions.

Leslie Kelly Hall commented that clarity is needed on faxing and servers. Savage referred to an OCR guidance on the topic. Although ONC staff plans to publish information on opt-in and opt-out this year, a specific date has not been set.

Nordenberg said that there are many issues with regard to ethical hacking of medical devices. The industry is very reluctant to disclose information on a hackable device to the public. The manufactures must become involved. Environmental controls are required. Nordenberg described a device-sharing initiative with FDA and others designed to (1) create a mechanism to take the published vulnerabilities in the database and (2) figure out how to assess and get them into a workflow for manufacturers to assess them and, if necessary, work on patches. Savage said that ONC is working with FDA on spillover and interdependency.

HITSC Co-chairperson Lisa Gallagher wondered what is being done to clarify and inform the regulatory release information on sharing threat data. She said that in her experience, people are not well-informed on the recent directive. Savage indicated that she is working on a grant opportunity to fill that gap. Congress created basic rules regarding the liability of threat sharing, and the U.S. Department of Homeland Security (DHS) is working on regulations. Communication with DHS and its agencies is ongoing. Gallagher said that the statute is clear in the areas of regulatory relief protection from liability and exemption from prosecution when the organization shares with DHS. The industry needs to know that the framework for sharing is already in place.

Miri said that the work of Savage and her colleagues had been very helpful to his previous employer. Although a number of great frameworks are on the market, some of them price out community hospitals. Frameworks that are free and easily distributable are needed. In response to his questions, Savage offered to invite FDA representatives to present information at a future meeting. As yet, there are no answers on ethical hacking. But if DoD can do it, it should be possible to develop a similar process for health care.

Tang observed that copiers now serve as fax machines. He wondered how these paper documents are covered by HIPAA: What is the guidance for deletion? Savage said that she will supply information at a later meeting. She referred to an OCR guidance on the application of the security rule to fax servers,

saying that she will check into its applicability to copiers. Consolazio asked the members to be considerate of the time restrictions.

Regarding a comment about infusion pumps, Nordenberg said that his organization is working through third-jurisdictional chasms in this domain. Although everyone looks to FDA to solve the problem, FDA has regulatory domain over devices only. In the hospital environment, accreditors and The Joint Commission are involved. The devices form a national biomedical device network that nobody planned or secured. Nordenberg is working with NIST, HHS, DHS, and other great partners.

Troy Seagondollar inquired about documents sent by mail or fax and wondered about a requirement to confirm receipt: What is the liability of the sender for the receiver's security? Savage said that the question is somewhat addressed in a fact sheet. She did not recall a requirement for verifying receipt, although she said that it may be good practice to do so.

HITPC and HITSC QPP Task Force: Comments on Notice of Proposed Rulemaking (NPRM)

Blake reminded the members that preliminary recommendations had been presented at a previous meeting. QPP Task Force Co-chairpersons Cris Ross and Tang reviewed the charge and presented general comments, saying that the proposed rule's objectives are good and responsive to stakeholder feedback. However, in the process of increasing flexibility, the proposed rule has become too complex, hard to understand, and challenging to implement. The proposed rule introduces many new options and requires participants to make choices in an unreasonably short time. It is especially challenging for small providers to understand and comply with requirements. Complexity will be a barrier for many to migrate toward APM participation. Requiring participants to meet Advancing Care Information (ACI) category requirements for certified health IT, reporting, and scoring decisions may discourage clinicians from participating in the QPP. Decisions on reporting as groups or individuals, measure selection, and whether to participate in MIPS or APMs will have significant impact on practices. Ross and Tang showed tables compiled by staff that compared the different components of MACRA with current and stage 3 requirements. These comparisons led to the recommended comments on focus areas for final rule improvement:

- Increase accessibility throughout the final rule and communicate a compelling story that is relevant to clinicians and consumers
- Develop additional visual materials to help providers understand the rule
- Further revise the ACI category for clarity
- Provide additional clarity around the CPIA Inventory
- Identify opportunities to further simplify the final rule and reduce burden for eligible clinicians
- Agree with reducing the number of objectives for ACI (vs the "alternative")
- Create an "on-ramp" for the ACI category for eligible clinicians who have not participated in the EHR Incentive Programs (possible strategies listed on slide)
- Significantly reduce process-oriented measures in the CPIA category and build on activities clinicians already are completing
- More clearly integrate the use of health IT into the CPIA category (possible strategies listed on slide)
- Reduce reporting burden for providers in APMs and assist providers in decision-making around APM participation (possible strategies listed on slide)

- Focus policies more distinctly and clearly on the Quality Payment Program's desired outcomes, especially interoperability and patient engagement
- Take further advantage of opportunities under MACRA to promote more seamless measurement and reporting infrastructure across stakeholders

Discussion

Jon White, ONC, expressed his gratitude to the task force and to Gretchen Wyatt and Beth Myers, ONC. He assured everyone that ONC takes the clarify-and-simplify recommendation seriously.

Miri referred to the slide 11 table, which he said was very helpful, and a 2018 requirement. He wondered whether the single patient requirement was the right measure to incentivize sharing. Why not use a NQF quality measure? Tang referenced HITPC's prior experience with Meaningful Use. Requiring the use of a function on one patient means that: 1) EHRs will be certified to have the functionality, and 2) that functionality will be implemented and used. It is the calculation of a numerator and denominator that has resulted in definitional confusion and extra burden for providers, and in the end the majority have exceeded the thresholds anyway.

Kelly Hall wanted elaboration on communication and discussion between the physician and patient. The rule should describe how technology can enhance communication with patients. Kelly Hall asked whether the task force had considered the topic. Ross replied that there was limited time to examine the interaction of these regulations. Slide 11's first row makes an explicit comment on messaging, which is a threshold requirement. The emphasis is on balancing stage 3 and QPP. Kelly Hall asked that the comments mention a need to clarify these issues. Tang added that the HITPC has learned that there are unintended consequences from being overly prescriptive. Outcome, not process, is the essential factor to consider.

Wolf wondered about any discussion of outcome measures that are sensitive to process. Tang reminded him that the charge was to comment on the NPRM. Quality outcomes come under another provision of the law. Ross said that slide 15 lists strategies to address these issues, as well as incentives to maximize patient engagement.

Floyd Eisenberg referred to slide 16's third bullet point, on bonus points for those who implement an eCQM on patient safety, efficiency, engagement, care coordination, outcomes, or cross-cutting measures. The task force agreed that repeating process measures was not recommended. The members wanted to have measures of interoperability and patient engagement in which there is a target outcome. However, how fast they could be implemented must be considered. Progress will be incremental, starting with interoperability components.

Josh Mandel raised an issue with the up and down arrows in the summary table, saying that he did not see anything regarding patient APIs. The single-patient requirement weakens the current requirement. Tang acknowledged that something had been left off the slide and will definitely be included in the transmittal letter. The API requirement will increase in 2018. Under meaningful use, the threshold would have been set higher than one. As stated in the NPRM, vendors must supply the function, and providers must turn it on, but no computation of the denominator and numeration is required. Mandel argued that the NPRM language does not require API be available to everyone. The CMS representative explained that in the performance score, there is room for additional rewards. Mandel continued to express concern. Tang said that the NPRM language is consistent with the goal of moving from fee for

service to what is important to the person. Ross said that Mandel's point is an important one and should be reflected in the final rule. This is another opportunity to clarify API requirements for certification.

Gayle Harrell referred to slide 12 and the on-ramp, saying that the inclusion of behavioral health care providers in scoring is significant progress. How will this be accomplished, and what about privacy and security requirements regarding behavioral health records, which vary by state? How would these differences be accommodated in ACI scoring? Tang said that under the NPRM, CMS can zero out the requirement for new participants. Blake interpreted Harrell as saying that different scoring may be needed depending on the state. Tang indicated that differences would affect the denominator. He was not sure how this was stated in the NPRM. Ross said that the burden for new participants will be significant. The task force did not attempt to rewrite the NRPM. The comments relate to the necessary but not sufficient requirements. New behavioral health providers will be subject to considerable difficulties, which should be recognized. Harrell said that the committees should discuss the implementation of this.

Miri declared that the difficulty of application of the NPRM to pediatrics should be addressed. Tang and Ross agreed. Blake commented that the transmittal letter should acknowledge that the NPRM does not deal with new EHR purchases. Tang reminded her, saying that there is a hardship exemption.

It was then moved and seconded to accept the comments of the QPP Task Force. The motion was unanimously approved by voice vote.

Action item #2: The comments of the QPP Task Force on the NPRM were approved for submission to ONC.

HITPC and HITSC Interoperability Experience Task Force Draft Recommendations

Task Force Co-chairpersons Jitin Asnaani and Anjum Khurshid showed slides and explained that the task force was charged with making recommendations on the most impactful policy, technical, and public-private approaches that could be implemented to improve the interoperability experience for providers and patients, as well as the following tasks:

- Assume that the stakeholder has access to a system(s) that can interoperate with at least one other system from outside
- Identify the top three to five most important needs for these stakeholders
- Narrow the scope of work to where the most (doable) impact can be made
- Make specific actionable recommendations for ONC, in collaboration with others (e.g., standards bodies, commercial parties and other Federal entities)
- Consider the Federal Health IT Strategic Plan and Interoperability Roadmap as a foundation.

The task force identified five broadly applicable use cases and seven distinct priority needs across the five use cases. These were described on the presentation slides. The members agreed that the interoperability experience is proportional to user delight and inversely proportional to perceived friction. Members then voted on the three highest priorities. Preliminary draft recommendations were presented for each of the top three priorities:

Ability to effectively utilize health information

- Create a joint task force to improve clinical information reconciliation across interoperability contexts (e.g., for what data and under what circumstances should data automation be expected, and what are the expected behaviors of individuals involved)
- Sponsor challenges centered around user-centered design opportunities

Potential elements of solution + key considerations:

- Automation of interop experience, from data import to "insights at point of care/need"
- Goal-centered design that drives meaningful clinical workflows
- Visual design that eases cognition
- Lean-forward policy solutions that use consistent outcome-based metrics to fully align incentives for providers and engage them to act on the data in a truly transformative way
- Awareness that not all data should be reconciled.
- Appropriately selecting content that is relevant – ignore noise and find key data
- Appropriate privacy and security safeguards for processing data
- Tools for usability testing
- Potentially going beyond "challenges" to sponsorship of pilots for reconciliation

Ability to encode data that is syntactically and semantically interoperable

- Create joint task force focused on recommending a path for standardizing non-clinical data
- Create work streams focused on separate semantic interoperability issues
- Understand the tools and opportunities that enable data to be efficiently captured
- Understand how natural language processing and data mining is being utilized in industry today to achieve semantic interoperability through unstructured data
- Continue or renew efforts with terminology stakeholders to improve the coverage and value of existing industry terminologies and code sets (e.g., LOINC)

Potential elements of solution + key considerations:

- Inform the ISA and get feedback from the ISA Task Force
- Incorporation of priorities as articulated by federal roadmaps, ISA; also impact on the interoperability experience where applicable (e.g., auto-reconcilable data elements)
- Commonly used terminologies that enhance data exchange and care coordination
- Engagement with EHR vendors to standardize data used nationally
- Data structure and standardization that allows multiple sources (consumer apps, devices, wearables, etc.) the ability to effectively and accurately transmit information to EHRs
- Standardized formatting of non-clinical health determinants
- Role and opportunity for NLP/data mining on social, behavioral and other data

Ability to exchange health information:

- Substantial components already within purview of API Task Force; incremental suggestion to API Task Force scope: requirements and considerations, if any, for other health IT systems (beyond EHRs) to enable Open APIs

- Highlight opportunities and best practices for successful incorporation of patient-generated data into the provider's decision-making process, e.g., formal case studies or research and sponsoring challenges, hackathons, etc.

Potential elements of solution + key considerations:

- Role of open APIs and associated standards/technologies (OAuth2, etc.) to support non-EHR and patient-facing data exchange
- Build on existing exchange capabilities
- Transparency of affordability of interfaces/exchange
- Acceptance of communication/data from patients, including technical and cost implications
- Variability of state to state HIE requirements and costs
- Transparency of cost burden to the consumer (providers and patients)

Final recommendations will be presented for action at the July meeting.

Discussion

Tang asked which recommendations are most relevant to the federal government. Khurshid replied that they recommended the convening of another task force to deal with that question. ONC has initiatives underway that may provide answers. The task force was not specific, because it recognized that there may be several ways to accomplish a recommendation, and sometimes a solution was not known. All recommendations are applicable to the federal government.

Kim Nolen observed that the cost requirements recommendations are very much related to the work of the 2017 ISA Task Force and could be incorporated into the ISA. Khurshid noted that the task force focused on demand rather than supply. One slide refers to the ISA.

Andy Wiesenthal commented that most of the content relates to providers. Patients often wonder whether interoperability actually happens with their information. Asnaani said that the recommendations apply to the patient's perspective as well (e.g., the cost of pharmaceuticals). Patients and clinicians are a team, which is a theme of the recommendations.

Harrell asked about the role of the federal government regarding interface costs. How can usability be improved and expenses reduced? Is there a role for certification? Khurshid explained that although the task force members talked about making a recommendation for certification, they decided that regulation would actually constitute a barrier. The best approach to usability is to make innovations more visible. The task force did not discuss interface costs. Price transparency could be a role for government. Harrell suggested that transparency be added to the recommendations.

Kelly Hall referred to the terminology section and asked that consumer taxonomy be included. There is opportunity for curation and reconciliation as new data points are provided. Any discrepancy between clinician- and patient-provided data is an opportunity to enhance communication. Kelly Hall asked that increase of consumer and provider communication to increase efficiency be added to slide 12. Also, there is nothing in the recommendations about precision medicine, in which the data are external to the EHR. Asnaani said that the co-chairpersons of the several task forces had agreed to deter to the Precision Medicine Task Force in that regard.

Jamie Ferguson said that the task force should build on and incorporate the results of previous committee and ONC work. Previously developed use cases should be used. Shared access models are neglected in the recommendations. The task force did not consider the National Strategy for Trusted Identities in Cyberspace (NSTIC), which is applicable to the charge.

Miri said that necessary and appropriate safeguards should be added to slide 16. Patient consent and choice should be considered. He wondered which of the three task forces is dealing with the capture of state variation in factors affecting interoperability. Khurshid said that certain issues must be dealt with prior to the consideration of state variation.

Referring to the first recommendation, Wiesenthal suggested a better alignment with value-based care. He suggested coordination with an ELTIS workgroup's work on a standard for health plans. Regarding the API recommendations, he declared that exchange of CDAs is not a viable business case. Only APIs provide a sustainable business case. Input from the venture community should be used.

Blake talked about the evaluation of the user experience and DoD hackathons. Users and hackers could work together to test usability. Teaching EHRs are being developed for use in medical education, and they could be a resource for testing usability. HHS is expected to issue recommendations on attributes for use in quality measurement. Coordination with NQF is important.

Chris Lehmann noted that specialties and subspecialties have different needs that should be recognized in task force composition. The use cases do not address variation in price transparency. Asnaani told him that variation in price transparency came up less frequency than the other priority topics.

Carolyn Petersen observed that the task forces vary in the extent to which patients and consumers are included. She encouraged more emphasis on consumers by this task force. Regarding the government's role in usability, she argued that some general principles can be applied. She pointed out that although greater usability of data is mentioned in slide 13, it is not captured in the recommendations. She suggested that the task force consider the difference between usefulness and usability.

Jonathan Nebeker argued that the focus on standards by the government is not useful. The government should focus on use cases and outcomes. Although VA data are mapped to traditional and nationally approved standards, they are not sufficient for interoperability. In addition to standards, ontologies must be considered. VA staff are working on a publication regarding NIST standards.

Seagondollar pointed out that the task force is recommending three additional task forces. The C-CDA) is called the summary of care. "Shared care plan" is another term. Seagondollar was concerned about the separation of clinical and social data implied in the first two recommendations. Using the example of asthma, he described that both medical and environmental information are important in health care. Asnaani assured him that task force members were aware of the interaction. However, their vocabularies for use in EHRs are very different, and different actions are needed. The capturing of social variables is in its infancy compared to clinical data.

Ou referred to the second recommendation on semantic interoperability. Referrals often result in duplicate orders. What is the role of government in improving standards to increase use? Khurshid said that a parsimonious set of standards is recommended. Efforts across agencies should continue. Work on LOINC® is not yet finished.

Rishel pointed out that LOINC® is not done because hospitals and small, local labs do not use it. There must be a way to motivate data providers to provide data in a format different from the one that they use. The aggregation of data for population health purposes makes uniformity essential. Khurshid agreed that that was a concern, but it was not in the top priorities. Rishel said that to be implemented, recommendations must include all factors related to their implementation.

Tang said that the nonclinical data area is an important one to target for improvement. The task force should consider how to move this along. A shared care plan could make a difference. A better understanding of the problem could result in the allocation of more resources. Tang instructed the task force to focus on what the federal government can do to improve the interoperability experience.

Public Comment

Mari Savickis, College of Healthcare Information Management Executives (CHIME), commented on MIPS and the hospital community. The NPRM puts hospitals and ambulatory providers on two different pathways. Although MIPS creates needed flexibility, it establishes two different sets of requirements. The requirements should be aligned. Time lines should be aligned, and hospitals should not be required to report prior to the 2019 reporting year. Starting stage 3 in 2019 would offer all actors adequate preparation time. CHIME is co-sponsoring a $1 million challenge on patient identification for 2017.

HITSC 2017 Interoperability Standards Advisory Task Force Draft Recommendations

Task Force Co-chairperson Nolen reported that the 2017 ISA Task Force is charged to develop recommendations for the HITSC in two phases. By July, the charge is to recommend the following:

- Updates to the ISA based on an analysis of public comments
- Structural and framing improvements to the ISA, including elements that could provide additional clarity and context for stakeholders that would use and consult the ISA
- Limited set of new "interoperability needs" that should be included in the ISA along with attributed standards and implementation specifications
- The explicit "best available" designation to a standard or implementation specification, where appropriate (and in consideration of available implementation experience)

After a brief description of the 2016 ISA, Nolen and Task Force Co-chairperson Richard Elmore showed slides and presented initial recommendations in seven areas:

Replace best available standards with recognized standards.

- Recognized standards will include voluntary consensus standards (see OMB Circular A-119 Revised) and related implementation specifications
- To be listed in the ISA, recognized standards should be approved by the governing standards development organization (SDO) (or equivalent governing body) as either a trial standard for pilot use (or equivalent) or approved for production use (or equivalent)
- Standards that are considered "emerging" may include broader standards that do not meet this criterion
- The ISA should serve as a filter to identify recognized standards which may be considered in a future regulatory process
- Recognized standards should be dynamically linked in the ISA to the applicable standards specifications and governing body statements regarding the individual standard's maturity

Improve use and function of standards already in regulation by incorporating additional implementation references:

- HL7 Structured Document Examples
- HL7 C-CDA R2.1 and the C-CDA R2.1 Companion Guide (to be balloted in September)
- Direct Trust Recommendations to Improve Direct Exchange
- Argonaut Implementation Guide
- NCPDP/HL7 Pharmacy eCare Plan V1.0 (Guidance on the Use of the HL7 Clinical Notes R2.1 Care Plan Template)
- Additional feedback and resources to be incorporated prior to final recommendations

Focus the scope on data, standards, and interoperability needs for CHIT and, when appropriate, include an appendix that references authoritative sources for other standards in health care, including security, administrative, research, and clinical trials.

- Define secondary data used for ISA purposes as the reuse of the same data that is collected for clinical care
- Include standards for interoperability which connect technologies outside the EHR, creating a path where data can be put in once (primary use) but used many times (secondary use)
- Identify "industry gaps" that exist (per task force and HITSC recommendations) in areas where standards likely would be valuable but are not known to exist. (i.e., data quality in patient matching)
- Deprecate listed standards once sufficient experience is gained with newer standards and approaches that offer a clear advantage over previous standards

Evolve to a more dynamic experience for users.

- Link to or embed content from websites like the ONC Interoperability Proving Ground demonstrating interoperability use cases
- Enable viewing of public comments and ONC responses in the context of which standards and interoperability needs they pertain
- Link to known entities which coordinate standards listed in ISA to address specific clinical needs and use cases
- Link to published assessments of a particular standard's maturity
- Link listed value sets to their publication in VSAC
- In addition to the links mentioned above, allow some content like annotations and available value sets to be updated more frequently that yearly, as industry evolves

Include the following ISA characteristics:

- The Adoption Level bubbles should be more qualitative in nature than quantitative when possible and should be referenced/sourced to how the adoption level was determined
- One consideration could be to have a descriptive field of what is known about Adoption Level.
- Source used to derive adoption level should be provided
- Link maturity assessments to known published criteria about the standards either from the SDO itself to other known evaluation entities (e.g., IHE Standards Matrix Criteria)
- Add a category under Standards Process Maturity to include categories of "ballot in development" that could reflect emerging standards which may be in rapid development

Employ the following API-based interoperability approaches:

- Add a section to the ISA which highlights key differences between API-based interoperability standards and previous approaches.
- Continue to focus on a use-case driven approach to interoperability guidance, but in so doing maintain clear distinction between the lower-level standards that make up the "building blocks" (e.g., FHIR, OAuth 2) and the higher-level use-cases that leverage the lower-level building blocks
- Higher-level use-cases should produce Implementation Guides that document their use of the core API standards, but which also include additional specifications and constraints, potentially including: use-case specific profiles of the required FHIR resources (including resource extensions, value sets, query parameters, etc.); use-case specific profiles for security standards such as OAuth 2 and OIDC (including authentication and authorization strategy, transport security, etc.); and orchestration patterns that define the sequence of interactions between the key actors and the access patterns to the core APIs (including sequence diagrams, network topology, etc.)

Consider the following standards criteria for patient matching:

- Data formats needed for submission for patient matching
- Standards for algorithms needed for patient matching
- Standards to assess data quality for patient matching
- When developing criteria for patient matching we should think beyond traditional attributes used today and look for other attributes and to other industries which 'link' people through other attributes and activities
- Commonwell - http://www.commonwellalliance.org/specifications/
- Sequoia - http://sequoiaproject.org/wp-content/uploads/2015/11/The-Sequoia-Project-Framework-for-Patient-Identity-Management.pdf
- New Interoperability Needs Work on gaps in coded values; value pairs: (i.e., LOINC for questions/SNOMED-CT for observations, etc.)
- A sub-group is currently working to develop recommendations on this.

The 2016 ISA proposed a number of research-related interoperability needs in the "projected additions" section. This list needs to be further refined to ensure only relevant and necessary "recognized standards" are listed in the body of the ISA.

Discussion

Ferguson referred to page 7, saying that "best available" should give preference to standards that meet criteria for accreditation. Page 8 should refer to use of the eHealth Exchange. A standard for the harmonization of terminology across implementation guides and NLM's work should be included in page 11. Regarding patient matching (page 14), the ISA should recognize NSTIC.

Kelly Hall said that it would be great to have guidance on the treatment of emerging and maturing standards in regulation. She referred to recommendations of the Precision Medicine Task Force and mentioned the helpfulness of charts. Harmonization with HIMSS and the White House effort on patient identity would be helpful.

Asnaani observed that the recommendations appear to be from the perspective of providers. He wondered who uses the ISA. Nolen reported that the task force also asked that question. Although there are no quantified data on users, the ISA is apparently used in procurements and developing technologies and, to a lesser extent, by vendors. A staff member said that ONC staff use it in working with sister agencies. He confirmed that there has been no systematic collection of data on use.

Wolf noted that the model for assessing maturity was a good one. He wondered about assessing data quality and maturity. Although the VA and DoD use standards, they continue to experience problems in moving their data back and forth. Elmore responded that data maturity is out of scope for the task force. However, one way to think about the topic is how well the information at the point of care has informed treatment. Wolf urged the development of intermediate steps and went on to talk about a developer-friendly way to move the standard forward such as was done with FHIR. FHIR has an interactive website. Nolen indicated that data quality could be incorporated into the task force recommendations.

Derr urged members to include long-term and post acute care in interoperability. White thanked Derr and welcomed the new members.

Public Comment

Savickis commented again, saying that long-term and post-acute care providers are eager to cooperate on interoperability.

Next Meeting: The joint committees will meet virtually July 27.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the June 8, 2016, joint meeting as corrected by Blake was approved unanimously by voice vote.

Action item #2: The comments of the QPP Task Force on the NPRM were approved for submission to ONC.

Meeting Materials

- Agenda
- Summary of the June 8, 2016, joint meeting
- Presentations and reports slides