



Health Information Technology Advisory Committee EHR Reporting Program Task Force 2021 Virtual Meeting

Meeting Notes | September 2, 2021, 10:00 a.m. – 11:30 a.m. ET

Executive Summary

The focus of the final meeting of the Electronic Health Record Reporting Program Task Force 2021 (EHRRP TF 2021) was to review recommendations for the Standards Adoption and Conformance Measures. TF members discussed the measures and provided feedback.

There were no public comments submitted by phone, but there were several comments submitted via the chat feature in Adobe Connect.

Agenda

10:00 a.m.	Call to Order/Roll Call
10:05 a.m.	Opening Remarks
10:10 a.m.	Recommendations for Standards Adoption and Conformance Measures
11:20 a.m.	Public Comment
11:25 a.m.	Final Remarks
11:30 a.m.	Adjourn

Call to Order

Mike Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the meeting to order at 10:00 a.m. and welcomed members to the meeting of the EHRRP TF 2021.

Roll Call

MEMBERS IN ATTENDANCE

Raj Ratwani, MedStar Health, Co-Chair

Jill Shuemaker, American Board of Family Medicine's Center for Professionalism & Value in Health Care, Co-Chair

Zahid Butt, Medisolv Inc

Jim Jirjis, HCA Healthcare

Bryant Thomas Karras, Washington State Department of Health

Joseph Kunisch, Harris Health

Steven Lane, Sutter Health

Kenneth Mandl, Boston Children's Hospital

Abby Sears, OCHIN

Sasha TerMaat, Epic

Steven Waldren, American Academy of Family Physicians

MEMBERS NOT IN ATTENDANCE

Sheryl Turney, Anthem, Inc.



ONC STAFF

Mike Berry, Designated Federal Officer, ONC
Seth Pazinski, ONC
Dustin Charles, ONC Task Force Lead

PRESENTERS

Gary Ozanich, HealthTech Solutions (subcontractor of the Urban Institute, an ONC contractor)

General Themes

TOPIC: RECOMMENDATIONS FOR STANDARDS ADOPTION AND CONFORMANCE MEASURES

Raj presented on the topic of using the ACK message to determine the success of submission.

Key Specific Points of Discussion

TOPIC: OPENING REMARKS

Jill Shuemaker and Raj Ratwani, EHRRP TF co-chairs, welcomed members. Jill informed them that this would be the final meeting of the TF and briefly reviewed the agenda for the meeting.

TOPIC: RECOMMENDATIONS FOR STANDARDS ADOPTION AND CONFORMANCE MEASURES

Raj invited Jim Jirjis and Ken Mandl to present the final draft of the recommendations for the Standards Adoption and Conformance measures. They displayed the TF's shared working Google document, and Jim explained that he and Ken reviewed all of the previous feedback and TF member comments. Jim highlighted the context that was added at the beginning of the section, including goals and guiding principles for how the market is being used to drive future policymaking. He then reviewed the agreed-upon and potential future recommendations for the numerators and denominators across the following measures:

- Use of Fast Healthcare Interoperability Resources (FHIR) profiles by clinician-facing apps
- Use of FHIR for patient-facing apps
- Use of FHIR Bulk Data Access
- Vendor – availability of apps
- Health system – cost of supporting apps

DISCUSSION:

- Steven Lane thanked the presenters for their work and stated that it goes beyond another level of clarity that will lead to valuable outcomes for ONC. He added that the challenge is determining which belongs in version 1 and which are future goals.
 - Jim responded that they created a suggested phasing plan for ONC, which was included. Steven responded that signals can be sent to the industry through this approach.
 - Raj commented that the number of measures in this domain was reduced somewhat, and thanked Ken and Jim for their work.
 - Sasha TerMaat commented that the denominators were being captured for context, while the numerators are not supposed to be directly associated with or divided by the denominators. She asked them to update the wording and added that the TF should consider how many numbers would be generated by each of the numerators. Prioritization must be done, and the TF should identify which of the numerators are most critical due to the large volume. Also, she noted that several terms, like site, still require definition.



- Jim responded that the co-leads were trying to get a sense of the distribution of activity across the country and patterns of usage by including site. They need to continue considering how to represent this with informatics.
- Sasha cautioned that too much ambiguity in measures leads to waste and suggested that the TF move this recommendation to the list of items for future consideration if further clarity is not reached.
- Ray asked TF members to share feedback to work through any issues that would keep them from including this recommendation in the report to the HITAC. He drew attention to Steven Lane's comment in the chat via Adobe with a suggested definition for "site." TF members discussed this suggestion
- Steve Waldren thanked the TF for the new introduction and suggested that this is the area of the TF's recommendations where the "complexity tokens" should be spent. He stated that the TF should not focus on the implementation guide but rather the resource types for any FHIR versions that are being implemented in the market.
- Steven Lane stated that the purpose of "site" must be defined before the TF can determine how it will be measured. He added that it is important to look at the various sites of care and the context of the care that is being provided. CMS has a list of codes that describes this context.
- Ken Mandl stated that there are diversity, health equity, and inclusion aspects of this measure to ensure that the benefits of interoperability are reaching all segments of the population.
- Sasha described feedback she has received over the years about how associations between e-prescriptions and tax IDs were not intuitive and stated that this kind of stratification could lead to the same type of issues. She cautioned the TF against using all of its "data complexity tokens" and added that a great deal of extra documentation and data storage would need to be invented to fulfill the recommendation (for reporting, the audit trail, etc.). She stated that there might not be an intuitive link and that the TF might inadvertently force the generation of a lot of paperwork that is not meaningful.
- Jim asked the TF to suggest other barometers that would provide insight into the distribution of use from a health equity perspective and would not be a new data element. He asked if patient-facing information on zip codes could be used to get at information around distribution.
- Sasha responded that a visit does have a location associated, but API calls done by clinicians or apps do not necessarily have links to encounters with locations. She asked the TF to consider if it is valuable to the industry to add stratification where it does not currently exist. She described how an EHR company like Epic could collect zip code information from systems used in their software and could then provide a total list of zip codes used. This cannot feasibly be done with API traffic.
- Steven Lane suggested further wording in the chat. Sasha responded that the TF should begin with the contextual information from the first two recommendations and then get more specific regarding sites in the future. This requires more development for each system to capture this information and is much more significantly complex. She cautioned that the data collected around sites might be inconsistent and not worth collecting to create a significant data set.
- Ken asked how the measures could determine the distribution of technologies making API calls without collecting "site" information. He stated that because ONC is currently focused on social determinants of health (SDOH) data, they would want to know if federally qualified health centers were not making API calls, for example.



- Sasha responded that Epic could differentiate by its different deployments and measure them separately and call them “sites” as a stratification, if necessary. She asked the TF to be cognizant that customers give permission for their data to be used but could be wary when it seems like it is identifiable to them. Also, she explained that Epic’s EHR deployment model is different from those of other developers, which might divide their deployments differently (i.e., all in one cloud together, many different deployments across multiple clinics in the same health system). There is no one common model of measuring sites.
- Bryant Karras supported Sasha’s comments and asked the TF to consider how this information will be used. He suggested that instead of requiring extra complexity, information about the geographic availability of these tools could be gathered from individual EHR vendors that do not have a multi-jurisdictional footprint.
- Jim discussed the phasing plan for the numerators.
- Jim Jirjis asked TF members to review the proposed recommendations around the denominators and explained the work the co-leads completed. He asked TF to comment on whether they should drop the additional denominator of providers with at least one documented encounter, adding that they did not see the marginal value over just using providers who have had at least one session.
 - Sasha TerMaat commented that she supported the recommendation that providers with at least one EHR session in the period to be deemed as “active,” though this could lead to provider logins to the EHR that do not involve actively seeing patients/providing care being counted (e.g., those doing research, analytics, etc.).
 - Jim responded that if a user has privileges to use the EHR, there could be a value-added activity that occurs if this is captured (more than just clinicians seeing patients). Steven Lane agreed that APIs can bring value to many different workflows beyond direct patient care.
 - Zahid Butt commented that having these measures as numerators or denominators is less useful than metrics around active user volume in a performance period, like the number of active clinicians using a certain version of FHIR per month. He added that a part of this volume is already in patient and clinician measures.
 - Ken proposed merging the recommendations to include active clinician users, per a specific amount of time, per FHIR standard. Zahid, Jim, and Ken discussed how to capture other, more granular metrics, like the number of encounters and API use, and Zahid stated that the TF could propose that more complex measures be added in the next phase. Zahid suggested that the number of active users could be a separate metric from the number of active sessions, which would not be tied to a specific percentage/ratio. Jim stated that both recommended denominators would measure different things and that both seem valid. Sasha agreed and added that there would be contextual counts that do not directly relate to the API call counts. Jim described how this information would be used within the industry marketplace to determine how and where the industry is growing, the amount of data being exchanged, and insight into the health of various aspects. Sasha described the potential uses of the data, depending on how it is measured.
 - The TF discussed whether to add the total volume of data transferred (gigabytes) to a later phase and the primary reasons for this metric (cloud services, the growth/use of this technology). The TF renamed the numerator as “Counts (usable as numerator)” and the denominator as “Contextual counts (usable as denominator).”



- Jim asked the TF to review the suggested recommendations for counts/numerators and contextual counts/denominators for patient-facing apps. He described previous conversations the TF held around the length of recording periods and asked the TF to consider if the number of patients who have had an encounter is a surrogate for either the volume or complexity of the population. However, he added that this could neglect to gain insight into who is using it outside of encounters.
 - The TF discussed whether to have two combinations: the distribution of use of all patients who have had an encounter and the percentage of how many patients using the app who have not had an encounter.
 - Sasha asked if this would stratify the information in the same way as the provider contextual numbers or differently.
 - Jim responded that they would be slightly different, and Sasha stated that this would double the report processing, resulting in the use of more complexity tokens. Jim agreed but emphasized that the complexity and effort would be worth it to track patient usage.
 - Steven Lane commented that patient-facing apps would primarily function outside of the context of face-to-face encounters with providers, so this would still be relevant in the context of the volume of care (but the TF cannot assume that those apps are firing in the context of that direct care).
 - Jim described how changes in the percentage of patients logging on but outside of the context of an encounter could provide insight in parallel with value-based care.
 - Sasha and Jim discussed the potential recommendations for the numerators and denominators, and Sasha inquired if there would be duplication with other, previously discussed sections with different measures. She stated that the various recommendations made by the TF should be stratified and prioritized similarly and described how they seem to be overlapping currently.
 - Zahid Butt agreed with Sasha that there is some overlap between the access and active user definitions. He asked if the measure would investigate portal usage, specifically, or just any patient-facing app. Jim responded that the measure would look beyond portal usage, and the TF updated the text of the second denominator recommendation accordingly.
 - Jim invited the TF co-chairs to comment on how to word the recommendations for consistency and to avoid duplication across the measures. Raj responded that the co-chairs would work with ONC and the Urban Institute to determine where the TF's intent should be captured and whether to make an overarching section within the document.
 - Jim stated both denominators should be included, as the first would give important information, while the second would capture use. The second recommendation was updated with the document.
- Jim asked the TF to review the suggested recommendations for counts/numerators and contextual counts/denominators for the use of FHIR Bulk Data Access, noting that many of the numerators and denominators were the same as previously described sections. He asked the TF members to comment on the definition of "user" in the suggested denominator of "per user type (payor, researcher, internal user, etc.)"
 - Jim explained that "write back" was not applicable and was removed. Bryant inquired why Bulk FHIR would not write-back and described the example of a registry writing back to the subscriber in the event of an update. Ken responded that this could occur but added that there is a less mature community activity around that with the apps. The TF agreed that the ability for Bulk FHIR to write-back to registries could be added at a later phase of work.
 - Ken described why the total volume metric would be important in contrasting the timeframes for the adoption of SMART on FHIR to Bulk FHIR, and this information could be used to determine lessons on how data moves through the healthcare ecosystem.
 - Jim referenced a comment left in the chat via Adobe and invited TF members to comment on the draft recommended metrics would illuminate who is using Bulk FHIR and at what level of granularity (clinician vs. non-clinician).



- Zahid asked Ken to comment on the importance of the use of FHIR Resources in this context. Ken responded that the resources were included for all of the metrics to see what resources are being transferred, used, and appear to be valuable and which are in API calls outside of the US Core Data for Interoperability (USCDI), which would indicate that the USCDI should be updated. This would assist in regulatory planning for best practices for the ecosystem. He stated that many FHIR resources that would be useful are not included in the USCDI, so this is an opportunity to add data science behind that regulatory update process. Steven Lane responded the USCDI Task Force has a recommendation around supporting the app ecosystem that will be presented to the HITAC at its upcoming meeting; the two TFs could point out the synergy between their recommendations. Potential costs they could highlight include hardware, cloud, operational, and software. Steven suggested listing the ones that most vendors could support with the lowest burden.
- Sasha commented that more information is needed around definitions (e.g., same issues with “per number of sites” as described earlier in the meeting) and how costs would be measured. She stated that “cost” may not be reportable (i.e., hardware processing costs) by the developer but that the metric could ask about license fees charged for a feature, for example. Jim supported the suggestion, and they discussed how the costs could be handled by the developer. Sasha explained that, though this might be a practical thing to measure, it might not be meaningful.
- Steve Waldren commented that fees could be a better term to use than costs and emphasized the need to boost transparency around implementation. Steven Lane agreed that determining how to measure costs has a great amount of value, so even if it is difficult to do, the TF should make its recommendations accordingly.
- Zahid suggested creating a definition for “cost,” and he inquired about the initial intent of the term. Jim responded that it initially meant the cost to the buyer/client but agreed that it could be better defined. He suggested “cost to client,” because capturing all additional accounting costs would be more complex. It could be revisited in the future.
- Ken stated that it would be useful to understand how the ecosystem uses FHIR bulk data, what it is weighted toward, and how this would inform which data elements are available, how payment programs could be designed around Bulk FHIR, if the use is increasing/decreasing, and for identifying barriers. It is important to understand other user types. Jim asked the vendor representatives to comment on if patient-requested versus health system-requested versus other could be measured requested. Ken supported these divisions between types of users, though there may not be patient requests for Bulk FHIR. He asked Sasha to comment on methods for distinguishing between third-party versus internal requests and whether further granularity could be distinguished among third-party requests.
- Zahid commented that analytics and quality measurement are use cases for Bulk FHIR, which is a back-end use instead of a more provider-facing use. He asked if an instance of a download could capture this information. TF members discussed how the back-end services acquire data outside the purview of the vendor.
- Jim asked if the reason for the request information was captured as part of the process to protect against information blocking and if it could be leveraged to answer these questions. Ken commented that back-end services pull and use data in their own data services/analytics engines, but he stated that Bulk FHIR requests will need their own authorization, which is an opportunity to include a taxonomy for the user in this section. Jim suggested that reason could also be included and asked if it would provide enough information for this phase. He invited EHR vendors to comment on whether this would be captured. Raj responded that Sasha had left the meeting.
- Jim asked the TF to review the suggested recommendations for counts/numerators and contextual counts/denominators for the measure of vendor – availability of apps and for the measure of health system – cost of supporting apps.
 - Ken commented that the word “cost” would be replaced with total fees charged.



- Steven Lane stated that there is a challenge of how measurements relate to certified functional and emphasize the need for balance in making recommendations that put in requirements for measurements that go beyond the certified functionality so that they can inform the future changes in certification.

Action Items and Next Steps

EHRRP TF members were asked to review the draft recommendations report and slide deck for the presentation to the HITAC and submit final comments as soon as possible. The TF co-chairs will review all recommendations and will finalize all materials for submission to the ONC and Urban Institute team on Friday, September 3, 2021.

Public Comment

QUESTIONS AND COMMENTS RECEIVED VIA PHONE

There were no public comments received via phone.

QUESTIONS AND COMMENTS RECEIVED VIA ADOBE CONNECT

Mike Berry (ONC): Welcome to the EHR Reporting Program Task Force meeting.

Zahid Butt: Trying to connect the phone

Jim Jirjis: Can you hear me

Steven Lane (he/him): I took a stab at adding a definition of site above in the Definitions section. We also reference "by site" in other metrics.

Steven Lane (he/him): I drafted the following as a starting place: "The definition of site, for the sake of this reporting, should be based on individual locations of care as specified using the CMS Place of Service Code Set. "

Steven Lane (he/him): I am sure others can improve on this.

Sasha TerMaat: Steven, how would an API call be associated with a place of service code set item?

Steven Lane (he/him): I think the goal is to identify where the user and/or patient is when the API or other measured functionality is utilized.

Jim Jirjis: good point

Sasha TerMaat: The EHR does not know where the patient is to measure that. There is no direct connection for clinicians either, unless the system required the clinician to identify a department or something. There would be new data storage to them store that with all API calls, which seems like a lot of effort.

Steven Waldren, MD: Is there a "security domain" relative to who gives permission to exchange data as the site?

Steven Lane (he/him): My EHR, which Sasha knows well, does force me to identify my department every time I log in, and orders, prescriptions, referrals, etc. are placed in the context of an encounter, which also has an associated department and presumably an associated location code.

Sasha TerMaat: API calls do not require an encounter context, though.



Steven Lane (he/him): API calls, supporting, e.g., CDS, would occur outside *[sic]* an encounter but could still be associated with me, the user, and my login department.

Steven Lane (he/him): Our goals should be to measure these variables "where possible".

Bryant thomas Karras MD (Wa DOH): just trying to say that The OCHINs and The Kaisers of the world may not be the best way to detect equitable distribution.

Steven Lane (he/him): But wouldn't API calls in the context of non-patient care workflows still be valuable??

Steven Lane (he/him): APIs could definitely support analytic and other uses *[sic]* of the EHR.

Steven Lane (he/him): Like provider-facing apps, patient-facing apps may regularly (primarily?) operate outside *[sic]* the context of encounters with clinicians.

Sasha TerMaat: Agree there is no encounter link.

Steven Lane (he/him): Agree that normalizing to the number of clinical encounters makes sense to provide volume-related context.

Sasha TerMaat: Will we have another chance to review with some of the edits that are happening now? I'd like to review whatever language we settle on for clarity.

Sasha TerMaat: Bryant, why would bulk FHIR address that challenge? Wouldn't it just move it to the FHIR format?

Bryant thomas Karras MD (Wa DOH): the subscription model *[sic]* would only create *[sic]* resource impact on elements that have updates

Bryant thomas Karras MD (Wa DOH): model*

Sasha TerMaat: But how would you know which ones are updated?

Sasha TerMaat: Folks ask if updates are available for a whole population because they aren't sure which ones are updated, right? I'm not sure why FHIR inherently changes that. To me it seems the same challenge would exist.

Bryant thomas Karras MD (Wa DOH): we move the info into a FHIR server rather than the production registry

Sasha TerMaat: Ah, so it's not a change inherent to the standard, more to your architecture

Steven Lane (he/him): Getting at cost metrics will be challenging for provider organizations, but it is worth starting down this path if we are ever to be able to calculate the value of this capability.

Steven Waldren, MD: maybe "fees" would be a better term than "cost"

Bryant thomas Karras MD (Wa DOH): @Sasha, yes but invisible *[sic]* to end user ... they just get the info... we assume bulk FHIR wouldn't *[sic]* need to be as real time as the traditional HL7 V XU

Steven Lane (he/him): To Ken's comment about the need to expand USCDI to support the app ecosystem, our USCDI TF will be presenting the following recommendation next week: "ONC should specifically consider and prioritize the data required to support a robust API/app ecosystem." Our taskforces should emphasize in our presentations the synergy between our work.



Abby Sears: I think this is really problematic for small practices. I don't think they can afford more costs to be able to get these measures done.

Sasha TerMaat: Bryant, I always get nervous when folks make assumptions about FHIR that seem like they could be true in other places. FHIR or other standards could be used on production or non-production servers, they could also be set up with real time responses or staging in both cases. I'm not sure that's an inherent feature of FHIR.

Bryant thomas Karras MD (Wa DOH): I need to learn more about Bulk FHIR's evalving *[sic]* features

Bryant thomas Karras MD (Wa DOH): evolving*

Steven Waldren, MD: Costs are to EHR vendor right! AS they are the reporter. EHRs would not know the costs of the providers.

Zahid Butt: Provider cost is what they pay for the EHR software/services

Bryant thomas Karras MD (Wa DOH): my comments were on "Use of FHIR bulk data" section

Steven Waldren, MD: Tangent: I added a suggested addition to the "Encounter" definition in the Google Doc. (Yellow Highlight)

Abby Sears: If our systems need more computing capability to capture the data for the EHR vendor, then the providers will carry those burdens. All of these reporting requirements will add to the infrastructure costs for the provider side of the equation.

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

[EHRRP TF 2021 Webpage](#)

[EHRRP TF 2021 – September 2, 2021 Meeting Agenda](#)

[EHRRP TF 2021 – September 2, 2021 Meeting Slides](#)

[EHRRP TF 2021 – September 2, 2021 Meeting Webpage](#)

[HITAC Calendar Webpage](#)

Meeting Schedule and Adjournment

Raj and Jill thanked everyone for their dedication, hard work, and participation in the EHRRP TF's meetings.

The co-chairs will present the EHRRP TF recommendations to the HITAC at its meeting on September 9, 2021.

The meeting was adjourned at 11:30 a.m. E.T.