Meeting Notes

Health Information Technology Advisory Committee
Health IT for the Care Continuum Task Force
March 29, 2019, 09:00 a.m. – 10:30 a.m. ET
Virtual

The March 29, 2019, meeting of the Health IT for the Care Continuum Task Force (HITCCTF) of the Health IT Advisory Committee (HITAC) was called to order at 9:00 a.m. ET by Cassandra Hadley, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC).

Cassandra Hadley called the meeting to order and then conducted the roll call.

Roll Call

MEMBERS IN ATTENDANCE

Carolyn Petersen, Co-chair, Individual
Christoph Lehmann, Co-Chair, Vanderbilt University Medical Center
Chip Hart, Member, PCC
Susan Kressly, Member, Kressly Pediatrics
Aaron Miri, Member, The University of Texas at Austin, Dell Medical School, and UT Health Austin

MEMBERS NOT IN ATTENDANCE

Steve Waldren, Member, American Academy of Family Physicians

ONC STAFF

James Daniel, ONC
Cassandra Hadley, Designated Federal Officer, ONC
Jawanna Henry, ONC
Andrea Jackson, ONC
Lolita Kachay, ONC
Alex Kontur, ONC
Stephanie Lee, Health IT for the Care Continuum Task Force Staff Lead
Samantha Meklir, Health IT for the Care Continuum Task Force SME
Elizabeth Myers, ONC
Carmen Smiley, ONC
Albert Taylor, Health IT for the Care Continuum Task Force SME
Maggie Wanis, ONC

GUEST SPEAKERS

Sherry Green, Sherry Green Associates
Stuart Myerburg, CDC
Jamie Parker, Carradora Health

Cassandra Hadley turned the meeting over to **Carolyn Petersen**, co-chair.

Welcome Remarks

Carolyn Petersen, co-chair, welcomed the group and reviewed the agenda.

Discussion – Pediatric Recommendations Wrap-Up

Chris Lehmann shared that he has received some feedback around recommendation 5 that the group may want to consider.

Al Taylor shared that there were a few areas where additional information was needed during past discussions. The four recommendations that will be covered are Recommendations 4, 5, 7, 10.

Recommendation 5: Synchronize immunization histories with registries

Al Taylor noted that this is an existing 2015 Certification Criteria that is implemented consistently in certified technology. He also received confirmation from the Centers for Disease Control and Prevention (CDC) that this is a well-implemented standard, although there are some functional problems.

- **Chris Lehmann** shared that the discussion around this was there is not consistency across registries about what is being forecast, and there might be discrepancies. It can take months to get this done.
- **Susan Kressly** commented that a significant number of clinicians in the field report that this is not working for them. Not only the exchange of data but the accurateness and the lack of resources from the state to implement smaller vendors in a timely fashion.
- **Chip Hart** commented that they have been exchanging this data for 30 years, but state variability is impactful. This is fundamental to child health, and he is very supportive, but it can be difficult to get this to work. The standards are not the problem.
- **Chris Lehmann** noted that the challenge is the interpretation at the state level.
- **Chip Hart** commented that one of the unintended consequences is that there isn't a universal school form nationally. NY is going to mandate a school form
- **Susan Kressly** when new standards are implemented, there is an overlap period where it breaks existing functionality.

Recommendation 4 - Segmented access to information

Al Taylor followed up from the previous discussion on this. There is a voluntary certification for data segmentation for privacy (DS4P), but it applies only to the creation and use of the consolidated clinical Document Architecture (CCDA). When something is sensitive the entire document is marked as sensitive. Each of the sections can be marked with machine-readable markings using these standards. The implementation does not specify markings outside of the -CCDA. There is not a standard to indicate how that marking is done on these data elements. It is his understanding that there is no standard that indicates that a document has sensitive information removed.

Susan Kressly expressed concern, she questioned at what point patient safety supersedes privacy and security. To not know whether there is something missing is unsafe care.

Recommendation 7 - Transferrable access authority

Al Taylor noted that the ability to change access in the record, the transferable part of this requirement is up to those running the EHR. There is no single standard.

- **Chip Hart** noted that his concern is not about philosophy or standards; it is about the user interface. If every discrete item on the record is flaggable, this could be difficult to implement and cause user frustration. It is difficult to expect an EHR to be able to set-up functionality that has the capability to account for the different needs across each state.
- **Susan Kressly** noted that the end-user needs to be able to make smart decisions that can be trusted.

Recommendation 10 - Flag special health care needs

Al Taylor shared that the prior discussion was around a single generic flag. There isn't a special health care code available. It doesn't mean there can't be, but it doesn't currently exist. ICD-10 could potentially be used.

- **Susan Kressly** questioned what the fastest path to success will be? How long will it take for there to be a code that is adopted?
- **Al Taylor** shared that the cycle time is about a year, but it depends on when in the calendar year the work begins.

Background/Overview – Opioid Use Disorder (OUD) Request for Information (RFI)

Samantha Meklir transitioned the conversation to the OUD request for information.

Health IT and Opioid Use Disorder Prevention and Treatment RFI

Section VI of the NPRM addresses Health IT for the Care Continuum:

- VI (A) Health IT for Pediatric Setting
- VI (B) Health IT and Opioid Use Disorder Prevention and Treatment
- Request for Information Questions for OUD RFI:
    - What's your general sense of how our existing Program requirements and the proposals in this rulemaking support use cases related to OUD prevention and treatment and additional areas for ONC consideration for effective implementation of health IT?

Neonatal Abstinence Syndrome (NAS)

- What are some health IT policies, functionalities and standards to support the NAS use case?
- Are there any ONC pediatric recommendations that are particularly relevant to the NAS use case?

Data Segmentation for Privacy (DS4P)

- What are your thoughts on the proposal to remove the current 2015 Edition DS4P-send and receive certification criteria and replace them with three new DS4P criteria (two for C-CDA and one for FHIR), as related to OUD? As related to pediatric care?
- What are some best practices, including processes and methods for displaying OUD information?

Electronic Prescribing and Prescription Drug Monitoring Program (PDMP)

- What are some effective approaches for the successful dissemination and adoption of standards including the National Council for Prescription Drug Programs (NCPDP) SCRIPT 2017071 standard (see section IV.B.2) that can support the exchange of PDMP data for integration into EHRs and also enable further adoption and use of Electronic Prescribing of Controlled Substances (EPCS)?

Leveraging Health IT and Prescription Drug Monitoring Programs (PDMPs) to Address SUD/OUD (LPASO) Presentation/Overview

Andrea Jackson shared preliminary findings from the PDMPs. **In** 2017 the U.S. Department of Health and Human Services (HHS) announced the five-point strategy to combat the opioid crisis.

Those approaches include:

- Enhancing PDMPs
- Improving provider education
- Connecting to drug treatment services
- Improving access to more complete and timely data and reporting

In June 2018 ONC funded the LPASO project.

- The purpose of this project is to assess health IT and PDMP technical and policy ecosystems in an effort to identify ways that health IT can be used to combat the opioid crisis. This project builds upon ONC's earlier activities and informs those underway by ONC and other federal agencies.

Project Outputs

- Nationwide assessment of key PDMP and health IT indicators
- Final report with recommendations to advance future state
- Strategies to assist states with implementing recommendations

Jamie Parker reviewed the findings.

Electronic Prescribing of Controlled Substances (EPCS) Background & Barriers to Adoption

- EPCS is a critical tool that enables healthcare providers to play an essential role in addressing the nation's opioid crisis. EPCS eliminates paper prescriptions, which can be stolen, forged or altered, and gives prescribers electronic access to a patient's prescription history to help identify potential overuse or abuse.
- The *SUPPORT for Patients and Communities Act* mandates the use of EPCS for all Medicare Part D controlled substances by January 1, 2021.
- Barriers to EPCS adoption as noted by states & subject matter experts as part of the LPASO project include:
    - Costs
    - Lack of provider education to fully understand benefits of EPCS
    - Multi-factor authentication
    - Multiple competing priorities

Prescription Drug Monitoring Program (PDMP)

- An electronic database that tracks controlled substance prescriptions in a state. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the epidemic and facilitate a nimble and targeted response.

PDMPs consist of the following components:

1. PDMP Processor
2. PDMP Database
3. PDMP Host/Operator
4. PDMP Integration in Health IT Systems
5. Interstate Data Sharing Hubs

PDMP systems comprise various processes and components that vary significantly across states. In any given state the PDMP system may include state-developed and vendor-based solutions along with the core PDMP database.

Sherry Green provided additional details regarding the LPASO project.

PDMP/EHR Integration

- The degree of PDMP and health IT (EHR, HIE, PDS) integration varies significantly within and across states, ranging from single sign on (SSO) to the PDMP from within the EHR, to full integration of PMDP data into the electronic medical record.
- According to one vendor, they have a commonly employed tool that enables PDMP integration with EHR systems in at least one entity in 38 jurisdictions. Secondary sources are not available to detail all vendor solutions to facilitate PDMP/health IT integration.
- Section 5042 of the SUPPORT Act describes the "Medicaid Providers Are Required to Note Experiences in Record Systems to Help In-need Patients Act" or the "Medicaid PARTNERSHIP Act." The act very specifically describes several requirements for record systems in the Section 1944(b) definition of Qualified Prescription Drug Monitoring Program (PDMP), including integrations of PDMP data into prescribing systems such as electronic health records.

PDMP/EHR Data Storage & Interpretation Policies

PDMP Data Placement/Storage in the HER

- 18 states with language that can allow, depending on legal interpretation, placement of PDMP data/report in medical record.
  - AZ, CA, CO, GA, IN, KY, LA, MA, MS, NH, NJ, OH, OK, TN, TX, VA, WA, WV
  - Florida proposed rule would allow placement.
- 7 states with language that applies access, use or disclosure policies governing medical or health information to PDMP data/report in medical record.
  - CA, CO, KY, NJ, TN, TX, WA
- 14 states with language that authorizes PDMP integration or interoperability with health IT systems but silent on placement.
  - DE, IL, IA, MD, NE, NV, NC, OR, PA, RI, SC, SD, UT, WI
- PDMP Data Interpretation Restrictions
  - CDS tools (i.e., risk scores and morphine milligram equivalents (MMEs)) to aid providers in delivering guideline recommended opioid therapy.

- No state has statutory or regulatory language prohibiting the development or use of interpretations of PDMP data such as risk scores, but most of those scores use proprietary algorithms.

PDMP Access Roles

- Considerable variability in the number (n= 8-25) and types (e.g., prescriber, pharmacist, law enforcement, delegate, etc.) of access roles identified in each jurisdiction.
  - 63 authorized access roles across 53 jurisdictions.
- Lack of harmonized definitions of user roles cause challenges with interstate data sharing.
  - The problem arises when one state allows data placement in the EHR and another does not. Once data is placed in the EHR, access roles defined by the PDMP are generally superseded by the EHR access roles.
- Most states do not allow behavioral health providers to access the PMDP.

Two Interstate PDMP Data Sharing hubs

- National Association of Boards of Pharmacy (NABP): PMPInterConnect (n = 47 states)
- Bureau of Justice Assistance (BJA): RxCheck (n = 4 states)
  - 29 additional jurisdictions are either interested in, or in the process of, connecting to RxCheck.

SCRIPTS Standards, Carmen Smiley

- Industry has moved from the 10.6 SCRIPT standards to SCRIPT Standard V2017071
- Ensures that prescriber and dispenser can make informed decisions
- Primary advantages are the accuracy of eprescribing

Susan Kressly noted that it is difficult to implement from an EHR developer perspective due to state laws. **Chris Lehmann** noted it would be valuable to have core standards across all states and territories.

Cassandra Hadley opened the lines for public comment.

Public Comment

There was no public comment.

Next Steps and Adjourn

Cassandra Hadley adjourned the meeting at 10:30 a.m. ET.