Meeting Notes

Health Information Technology Advisory Committee
Health IT for the Care Continuum Task Force
April 5, 2019, 09:00 a.m. – 10:30 a.m. ET
Virtual

The April 5, 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 Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC).

Lauren Richie 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
Aaron Miri, Member, The University of Texas at Austin, Dell Medical School, and UT Health Austin
Steve Waldren, Member, American Academy of Family Physicians

MEMBERS NOT IN ATTENDANCE

Susan Kressly, Member, Kressly Pediatrics

ONC STAFF

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

GUEST SPEAKERS

Chris Moesel, MITRE Corporation
Sharon Sebastian, MITRE Corporation

Call to Order

Lauren Richie called the meeting to order and turned the meeting over to Christoph Lehmann, co-chair.

Welcome Remarks

Chris Lehmann noted how happy he is to welcome guests from the MITRE Corporation, who have worked with the Agency for Healthcare Research and Quality (AHRQ) on a topic that the task force is charged with discussing. He shared that the task force will have some presentation and demo's today and he's looking forward to that as it suggests the task force's work is now pivoting. He went on to discuss that the task force has been focusing on the pediatric EHR format and EHR pediatric requirements in the last call. He further noted that while they will still address pediatric EHR format and EHR pediatric requirements on this call and future calls, they will now begin moving to the other agenda items. He then turned it back over to Carolyn Petersen, co-chair for her words of welcome.

Carolyn Petersen, co-chair, noted how excited she was to have a guest to present the demonstration and turned it over to Sharon Sebastian and Chris Moesel of the MITRE Corporation.

Agency for Healthcare Research and Quality (AHRQ) – MITRE Clinical Decision Support (CDS) Presentation/Demonstration

Sharon Sebastian of the MITRE Corporation introduced herself and provided a brief explanation of her background which included her role as a clinical informaticist at the MITRE Corporation. She has a background in nursing and is the project lead for CDS Connect. She then provided background information to provide context for the demo Chris Moesel was slated to provide. Sharon explained how the CDS Connect project is sponsored by AHRQ to advance evidence into clinical practice. By developing prototype systems in schools that can help with creating, sharing and implementing decision-support and health IT systems, it makes it easier and more accessible for healthcare organizations. She noted that the primary system developed by the repository is called CDS Connect. The repository is available on the internet, and it is a database that hosts decision-support logic that is publicly available and free to download and use. She went on to explain that currently there are over 50 artifacts or pieces of logic available that are free for any organization to access.

There also is an offering that eases the development of interoperable standards-based decision-support. Each year, they take on a different use case to inform the enhancements of these systems. Decision-support is developed in a designated domain that is piloted with a partner healthcare organization. The pilot reveals lessons learned, how the artifact performed, and results of the integration testing and use. She went on to explain that the clinical domain that was selected was pain management and opioid prescribing. The Centers for Disease Control and Prevention (CDC) guidelines for prescribing opioids for chronic pain were used as the evidence-based source to inform the development of the decision-support. The guidelines include 12 recommendation statements to help providers determine when to prescribe opioids, if they prescribed them how to do it safely, and if the patient begins to misuse opioids how to treat opioid use disorder. She explained that when they decide what they want to express as decision-support, they have a few unique things they consider. They don't want to overlap with any decision-support in that domain that is publicly available. For example, they knew the CDC was sponsoring decision-support work to express each one of their recommendations as decision-support logic, and they were doing a one-to-one correlation - one recommendation expressed as one piece of CDS logic that provided an intervention that was specific to where that would fall in the workflow. That work is co-led by HITAC member, Ken Kawamoto. She noted that he may be slated to present a demo in

the future. She went on to explain that since they knew that work was going to be publicly available, they didn't want to overlap and do a one-to-one translation.

Whatever is developed needs to be broadly used by nearly any organization. For instance, developing a specific PDMP integration and display for a unique pilot site in Oregon which uses NextGen may not be applicable to an organization in Florida that uses Epic or even another organization that uses NextGen because each implementation can be so different. They want to be sure they develop something providers want; something that makes things easier for them that is not already available in most EHRs and feasible to be integrated within their timeline. She noted that they came up with a variety of options and presented them to about 12 different pilot organizations. One idea was to more closely align to the Center for Medicare and Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) program. Ultimately, the number one request by every organization they spoke with was a pain management dashboard that provides a summary view of all the clinical factors that should be considered when managing a patient's pain. She noted that most EHRs will offer some summary views for prominent conditions like diabetes or congestive heart failure, but none seem to offer one for pain management, making this the right choice. They also heard it would reduce the level of effort for a provider having to navigate between the problem list, medication list, and lab results, to get a full view of the patient's history prior to making the next pain decision.

Sharon shared a slide that divided the summary into four sections. The first section is the pertinent medical history and that displays conditions in the patient's record associated with chronic pain (e.g., lower back pain, spinal stenosis, and fibromyalgia). In that section, there is a display of factors that increase the likelihood that for harm if an opioid is prescribed to that patient. That is where substance use disorder, depression, pregnancy would be listed. All of those factors come directly from the CDC guidelines.

The next section lists pain assessment scores over the past two years, and Sharon explained how they would have liked to have included the patient's goal for their pain, but it was not something their pilot organization and the providers within that organization routinely captured. She went on to say that this is, unfortunately, something common across most practices and most EHRs. Further, if it is captured it is captured as free text, which creates a fair amount of work that would need to be done to get that into a structured field.

Sharon went on to describe that in the summary they include historical treatments that have been ordered or tried in the past two years including medications and nonpharmacologic treatments and finally any evidence of additional considerations that could pose a risk. She noted that the summary was designed to be clinician facing during the training, but they encouraged clinicians as they became comfortable to consider tilting the screen so patients can see their summary and use it as a way to promote shared decision-making and get the patient’s buy-in to the treatment plan. Within the user interface, they did include some contextual flags to highlight areas of concern for the clinician. Ultimately, the summary itself doesn't make any treatment recommendations based on what is populated in the dashboard. It pulls the information needed for the provider to make the best decision possible. She then turned it over to Chris Moesel to discuss the display.

Chris Moesel, MITRE Corporation noted that he would walk through a brief demonstration of CDS Connect as well as the pain management dashboard. He mentioned that if they are interested, they can

go to www.cdsconnect@cds.arc.gov. Several CDS initiatives are highlighted at this site. He prompted the task force to click on CDS connect to be led to the portion that represents the current project. Chris mentioned that the task force can learn all sorts of different information about the project.

There is a collection of CDS artifacts that are all derived from evidence-based standards of care and expressed using international data standards and things like Health Level Seven (HL7) clinical quality language. The first artifact he shared was the pain management summary. He noted that there are additional reports that are hosted there for awareness that they exist.

He shared the SMART on fast healthcare interoperability resource (FHIR) application (app), the pain management summary in the Smart on FHIR gallery, and the open source code on GitHub.

He shared that when CDS is covered, it's often related to four knowledge levels:

1. The first is narrative. Narrative is basically the prose or the guideline that describes what is being done.
2. Semi-structured is a bulleted list and provides a way the user can get a better understanding of the logic.
3. Structured is when we use the standard like the clinical quality language (CQL). It is intended to be an author friendly language for describing CDS and electronic clinical measurement logic.
4. Executable is when they implement at a pilot site and make it executable, and that might include any site-specific mappings.

He leads the task force to the pain management summary in the SMART app gallery. He notes that SMART on FHIR is a way to allow third-party applications to be launched from an EHR and call back to the EHR. It uses the FHIR standard to do the data exchange. It is a great way to extend and EHR capability without having to do any proprietary work in the EHR.

One challenge that was encountered was the use of Argonaut which is the most popular flavor of FHIR in implemented systems. Argonaut only defines vital signs, lab results and smoking history. It does not define assessments. Custom work was also done at the pilot site to expose these pain assessments and others through the FHIR API.

He shared the Morphine Milligram Equivalent (MME) display in the pain management summary. At the pilot organization, they were using EPIC, and they were in the process of integrating a capability where EPIC could calculate the MME and provide a value.

He noted that they used the Smart on FHIR JavaScript client library and an open source library for executing CQL and it is all included with instructions on how to launch it.

In closing, Chris emphasized that it would be helpful to hear from Ken Kawamoto regarding the work he is doing with CDS Hooks for additional insight.

Discussion

Chris Lehmann questioned where in the workflow what was demoed would happen.

- **Chris Moesel** mentioned that his expectation was that this would happen at the point of care while a patient is with the clinician, especially if the patient is experiencing pain and the clinician and patient need to make a decision on how to manage that pain.
- **Sharon Sebastian** added that it's likely only after an assessment has been performed.

Chris Lehmann questioned if there is anything that would incentivize physician to use this tool.

- **Sharon Sebastian** responded that there isn't to her knowledge.

Chris Lehmann expressed his appreciation, as it is a great dashboard that aggregates the necessary information but reiterated that he only sees people use things if they are incentivized. He also stated that he loves the fact there will be a central tool to calculate the morphine equivalent dose because he thinks there is no need for everybody to reinvent the wheel if the new medication comes on the market that has a different conversion factor and thinks that is an excellent future development.

- **Sharon Sebastian** replied that similar feedback was received from physicians using the tool who tended to use it for really complex patients that had a lot of pain and they had tried a number of things. That is when they really went searching for it. If it was a simpler case, they did not.
- **Chris Lehmann** agreed that for the patient to see multiple specialists, this makes sense because it reduces the load significantly. He also suggested that flagging a high MME the same way absence of data is flagged probably not, from a design point, the best. He encouraged the team to consider revising that as a suggestion.

Chip Hart, Member, PCC added that he is always interested in the pediatric-specific clinical decision support. He is reviewing the FHIR app, and it did not seem to target the audience that pediatricians would be looking at. He noted that he understands that there are good reasons that pediatrics is left off, but this is where opioid dependence starts. For instance, what is the one thing they need to get them to pay attention to this because we're not generally talking about a patient with a massive history?

- **Sharon Sebastian** understood Chip Hart's point. However, she mentions that because they took a more general view of just compiling information, they were hoping to lower the age limit to make it any age, but indirectly aligning to the CDC guidelines, they specifically cite adults 18 years or older. She suggested looking for additional evidence that might be more specific for their age.

Steve Waldren, Member, American Academy of Family Physicians noted that these modules are based on one recommendation from the CDC. How do you handle the interdependencies?

- **Chris Moesel, MITRE Corporation** answered that he thinks they have not orchestrated that yet, but Ken Kawamoto may have more to share.

Samantha Meklir thanked the presenters and transitioned to the supplemental requirements related to the recommendations that the task force previously reviewed.

Remaining Supplemental Children's EHR Format Requirements

Samantha Meklir shared that she wanted to provide an opportunity for the group to discuss items that should be removed from the technical worksheet. She walked through the supplemental children's format requirements for each of the ten recommendations to determine items that should be removed.

- **Recommendation 2: #2: Alert based on age-specific norms**
  - The group agreed to remove this item
- **Recommendation 3**
  - **#2 - Record parental notification of newborn screening diagnosis.**
    - **Chip Hart** expressed concern about supplemental 2 – confused on the VDT aspect of this, stating it can be done with a free text field
  - **Chip Hart** expressed concern about #3 - Authorized non-clinician viewers of EHR data, but based on the discussion there was agreement that this was just the capture of the information.
  - **Chip Hart** expressed concern about #4 - Document decision-making authority of patient representative, as this information is difficult to capture regardless of the mechanism.
    - **Chris Lehmann** noted that all this requirement asks for is the ability to document. He suggested that this should not be captured in a free text field though.
- **Recommendation 4: #1 - Problem-specific age of consent**
  - **Chris Lehmann** expressed concern about the robust information that would be needed.
  - **Chip Hart** commented that this is asking EHRs to provide legal decision support which is not appropriate**.**
  - The group decided that this should be removed, as it is not implementable as is.
- **Recommendation 5: #1 Produce completed forms from EHR data**
  - There was a lot of discussion regarding the variances across these forms. There is no computable language for
  - **Chris Lehmann** suggested leaving this in as it is, as there is work being done around sharing immunization data.

Samantha Meklir asked the task force members to share any tools or resource that they thought should be shared.

Opioid Use Disorder (OUD) Request for Information (RFI) – General Discussion & Electronic Prescribing and PDMPs

Carmen Smiley shared additional information related to the Interoperability Standards Advisory (ISA).

- The ISA identifies interoperability needs, associated technical standards, and implementation specifications within the ISA that support certain high priority functions in health IT, including EHRs, in the delivery of healthcare to prevent and treat opioid use disorder (OUD) and other substance use disorders (SUDs) and is not exhaustive.
- Specialty Care and Settings functionality for opioids and pediatrics
  - Allows a Prescriber to Send a Prescription to a Pharmacy for a Controlled Substance
  - Allows a Prescriber to Communicate Drug Administration Events
  - Allows a Prescriber to Communicate with a REMS Administrator
  - Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data
- New functionality supports "Specialty Care and Settings" to display a list of interoperability needs supporting particular care needs or settings, including Opioids (prevention and treatment) and Pediatrics

- There are also details of state and interstate prescription drug monitoring program (PDMP) data exchange

Electronic Prescriptions for Controlled Substances (EPCS) is supported by the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard.

- The Drug Enforcement Agency (DEA) currently tests to NCPDP SCRIPT v10.6 for EPCS
- NCPDP released v1.0 of their PDMP Reporting Standard Implementation Guide Jan 29, 2019

Steven Waldren questioned why the highly adopted eprescribing infrastructure isn't leverage? Why is there another set of standards and transactions for opioids?

- **Carmen Smiley** noted that SureScripts is using the SCRIPTS standard.

Samantha Meklir noted that the task force will discuss perceived challenges and opportunities related to EPCS during the next call.

Lauren Richie opened the lines for public comment.

Public Comment

There was no public comment.

Comments in the Public Chat

Al Taylor, ONC: can we pull up the supplementals

Carmen Smiley: https://www.healthit.gov/isa/allows-a-prescriber-request-a-patients-medication-history-a-state-prescription-drug-monitoring

Next Steps and Adjourn

Lauren Richie adjourned the meeting at 10:30 a.m. ET.