Health Information Technology Advisory Committee

EHR Reporting Program Task Force 2021 Virtual Meeting

Meeting Notes | July 29, 2021, 10:00 a.m. – 11:30 a.m. ET

Executive Summary

The focus of the Electronic Health Record Reporting Program Task Force 2021 (EHRRP TF 2021) meeting was to continue to discuss the preliminary recommendations for the Patient Access Measure and to review preliminary recommendations, and discuss the Public Health Measures. Jill Shuemaker and Raj Ratwani, EHRRP TF co-chairs, welcomed members and reviewed the agenda for the meeting. Steve Waldren reviewed the preliminary recommendations created following the previous meeting for the Patient Access Measures. Sasha TerMaat and Bryant Karras presented the pre-work that they completed on the Public Health Measure domain. TF members discussed the measures and provided feedback.

There was one public comment submitted by phone, and 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.	Preliminary Recommendations for Patient Access Measures
10:25 a.m.	Discussion of Public Health Measures
11:10 a.m.	Preliminary Recommendations for Public Health 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 10:02 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 System
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
Michael Wittie, ONC Program Lead
Dustin Charles, ONC Task Force Lead

PRESENTERS
Gary Ozanich, Urban Institute
Fred Blavin, Urban Institute

General Themes

TOPIC: PRELIMINARY RECOMMENDATIONS FOR PATIENT ACCESS MEASURES
Steve Waldren presented the feedback that he and Sheryl Turney captured during the discussion at the previous TF meeting of suggested recommendations for the Patient Access Measures domain. TF members discussed the preliminary and potential recommendations and provided feedback.

TOPIC: PRELIMINARY RECOMMENDATIONS AND DISCUSSION OF PUBLIC HEALTH MEASURES
Sasha TerMaat and Bryant Karras presented the pre-work they completed on the Public Health Measure domain. TF members discussed the proposed preliminary measures and edits to the measures and provided feedback.

Key Specific Points of Discussion

TOPIC: OPENING REMARKS
Raj Ratwani, EHRRP TF co-chair, welcomed members and reviewed the agenda for the meeting. He briefly referred TF members to the EHRRP TF 2021 charges, which were included in the presentation materials. He stated that following the previous TF meeting and discussion, slight changes were made to the meeting process, and key points included:

- The TF lead(s) to present initial thoughts and recommendations
- All TF members will discuss
- The Urban Institute team will document agreed upon new consensus recommendations and other recommendations for further discussion (documented separately)
- Recommendations report template will be used to record emerging themes from discussion and projected during the meeting
- TF co-chairs will summarize initial recommendations that emerged

PRELIMINARY RECOMMENDATIONS FOR PATIENT ACCESS MEASURES
Steve Waldren presented a recap of the recommendations that emerged from the previous EHRRP TF's meeting and discussion around recommendations for the Patient Access Measures. He explained that the TF got a consensus agreement on two topics:

- The TF decided to prioritize the measures as they were listed, with the first being the highest

and so forth.

- TF agreed that the definition of "an active patient" would be a patient that has had one encounter within the reporting period.

DISCUSSION:

Steve explained that several items were discussed by the TF at the previous meeting but that the TF did not come to an overall consensus to adopt them as recommendations. These were detailed on slide #13 in the presentation and included:

- Define a list of CPT terms for encounter types for an active patient (e.g., Should telemedicine be included?)
  - No TF members objected, so Steve and Sheryl offered to create strawman recommendations to present to the TF at a future meeting.
  - Zahid Butt inquired if the definition includes inpatient encounters as well as ambulatory encounters. Steve Waldren suggested including both because some are only certified for one of two environments. Zahid recommended using the SNOMED codes (instead of CPT) for inpatient and offered to provide further assistance. Steven Lane stated that these should be product-specific. Sasha TerMaat was concerned that if a patient has both an ambulatory and an inpatient visit, it would be difficult to log/specify them both/for both products (portals). Sasha and Steven suggested aggregating by products and that both products should be counted towards someone being an "active patient."
  - Zahid suggested creating stratifications around inpatient, ambulatory, and at the patient level, but he noted that it could be hard to stratify if the measure is at the patient level.
  - Steve Waldren suggested that item is important and could be moved up to the list of topics with full TF consensus, following further discussion/clarification offline. Sasha suggested making the denominator distinguish between the ambulatory and inpatient domains via the SNOMED and CPT codes. This would indicate the product used. The numerator options, app authorization and portal access are not necessarily ambulatory/inpatient product specific and would be reported regardless.
- For Patient Access measure 1, determine if proxy (caregiver/other) use needs to be captured.
  - Steve suggested that this recommendation might be too complex at the current time but asked to keep it for the future.
  - Sasha asked for the following clarification: would the measure explicitly exclude proxy use, or would the measure state that the reporting developer would not be required to report proxy use differently than patient use. Steve Waldren stated it should be the second definition, and Steven Lane agreed that no differentiation should be made between patient access and proxy access, though differentiation could occur in the future.
- For Patient Access measure 2, capture the apps by the number of users– 10 users, 100 users, 10,000 users, or only report if the app has over 100 users.
  - Steven Lane suggested that the TF prioritize its goals to ensure the success of the program. He suggested that the orders of magnitude should be used and that 1,000 users be added to the list.
- Consider measuring the ratio of access to the patient portal versus third-party apps.
  - Steve Waldren explained that he submitted this item but suggested that this may not be a top priority for the TF at this time.
  - Sasha TerMaat suggested that if the numerators 1a, 1b, and 1c were all reported, it should be possible to manipulate the data to get a ratio. TF members agreed that this is the case and suggested removing this recommendation.
- Consider collecting gender and other social determinants of health (SDOH) data including sexual orientation and gender identity (SOGI).
  - Steve Waldren summarized previous TF member concerns with regard to the complexity of collecting this information, especially when some data are already included.

- Raj Ratwani suggested including this item and pulling it into a cross-cutting list of recommendations. TF members discussed if this recommendation applies to patients/users or providers/those purchasing the software. Steve stated that it should just apply to the patient. Zahid Butt stated that gender and ethnicity are the most readily available and most easily collected data now.

Due to time constraints, Raj explained that the rest of the work on these recommendations and potential recommendations would occur during offline work.

TOPIC: PRELIMINARY RECOMMENDATIONS AND DISCUSSION OF PUBLIC HEALTH MEASURES

Jill Shuemaker directed TF members to slide #15 in the presentation, where the Public Health Information Exchange measurement domain was detailed, and she explained that Bryant Karras and Sasha TerMaat would be the TF leads presenting the Public Health measures. Fred Blavin of the Urban Institute discussed the motivation for the creation of the draft measures and the questions that they were meant to address. He discussed Measures 1 and 2 and the related reporting elements and format, which were included in the presentation deck on slide #16. Discussion questions were also included in the slides.

Bryant Karras explained that he and Sasha TerMaat noted that the Public Health measures focused on the immunization registry components (reporting of vaccine delivery to public health, immunization registries, bidirectional query and response capabilities to get histories used in clinical decision-making processes). He recognized the current importance of work on these measures, especially in light of the COVID-19 pandemic. He shared that he and Sasha met with the American Immunization Registry Association (AIRA) and other key subject matter experts who were involved in previous TFs, hub activities, interstate exchanges, and more to better understand how to represent the current state. He invited those the TF members consulted during pre-work to participate during the public comment period or in the chat.

Sasha captured the discussion themes and TF member comments in the working document and reviewed all agreed-upon recommendations following the discussion. These included:

- Agreed upon recommendations for sending vaccination data to IIS:
  - We suggest the denominator of measure 1 be updated to “Number of immunizations administered.”
  - We suggest the numerator of measure 1 be “Number of administrations whose information was electronically submitted to a registry.”
  - These updated denominator/numerator suggestions help address the confusion of the numerator being larger than the denominator, which would be confusing.
  - We suggest stratifying the numerator by the registry submitted to, and avoiding the complexity of attempting to stratify by state.
  - A goal is to minimize burden on provider organizations in data collection.
  - We suggest that this measure have the same reporting frequency of the other measures in the program: reported annually for a 12-month reporting period, no lookback necessary.
- Recommendations for further discussion:
  - Consider that developers may have to change their agreements with providers to be able to report their data.
  - Any stratifications would have to be clearly defined for consistent reporting (the state of the registry, the state of the patient’s address, or the state of the provider’s office location).
  - Stratifications are possible; we will want to prioritize where to invest in that complexity.
  - There is interest in identifying success of messages transmitted, a clear definition of what would constitute a successful message would be necessary and the group would need to prioritize this complexity.

DISCUSSION:

Bryant discussed the key questions that he and Sasha prepared, following their work prior to the meeting. These included:

- To what extent do state laws prevent immunization data from being shared?
  - Sasha added that this question extends to data use agreements in the industry between EHR users and EHR developers. If these agreements do not permit this type of data collection and use, they would have to be amended for the purposes of the reporting program, similar to what the TF discussed regarding the Patient Access domain.
- Which individual characteristics should we collect the measures by? Would heath IT developers have access to data on these patient characteristics (e.g., age)?
  - Sasha added that any amount of stratification will have some amount of "complexity token," and the TF must prioritize where they will spend their "tokens" across this and the other measures. The age of the patient is simpler than the state, setting, or other characteristics, and she discussed reporting complexities, hardware needs, and challenges related to the state.
  - Bryant stated that these would be annual measures for a mobile population. He suggested choosing the state for the location of the provider. Sasha suggested the state should be where the immunization registry is/where the query is submitted to by the provider. They discussed various ways by which providers report to registries and related complexities, and Jill encouraged the TF to align to existing programs and to avoid creating additional burden for providers.
  - Steve Waldren inquired about the numerator and asked what is based on/how it should be reported. Sasha suggested that the denominator should be the number of immunizations administered, and the numerator should be the number of administered immunizations that were electronically submitted to the registry. Stratification of the numerator (for state of registry, age of patient, etc.) could occur without creating a separate numerator. Bryant suggested adding "successfully submitted to the registry" to the wording. Mary Beth Kurilo added a comment to the public comment chat that, as a note, some immunization information systems (IIS) function at the county/city level (e.g., Philadelphia, NYC), so a decision will need to be made to segment them out or roll them up at the state level. Sasha suggested that any city/jurisdiction reporting could be added as a stratification in a straightforward manner. Bryant added that some registries are operated at the county level. Sasha suggested stratifying at the location of the registry (could be state, municipality, county, etc. and could have multiple).
  - The TF decided to add the recommendation that the location of the vaccine registry be used instead of the state, and stratification could occur within the location.
- Queries via portals would be excluded from Measure 2. To what extent is this a limitation?
  - Bryant stated that when this measure is analyzed, recognition should be made that some providers have elected to use a manual login portal for reporting vaccines administered or immunization forecasting. It will be difficult to tease this information out from the measure.
- For Measure 2, should the denominator be "encounters," E&M visits, or vaccinated individuals?
  - Bryant and Sasha summarized previous TF discussions on this topic and shared comments made in the Cross-Cutting Issues TF shared document. The denominator was previously the number of patients with encounters.
  - Bryant noted that there was a suggestion to make the denominator encounters at which a vaccine could be delivered. However, it would be impossible to determine this from an electronic medical record system (EMR), so the TF must choose a different denominator.
  - Sasha agreed that it would be simpler to define by encounter rather than by individual (could have had multiple encounters and multiple reports). Bryant inquired about the length of time over which multiple encounters are relevant.
  - The TF discussed changing the denominator for Measure 2 "encounters" and changing the

numerator in Measure 1 from "the number of individuals with an immunization administered" to "number of immunizations administered." Steve Waldren agreed with the use of "encounter" for the Measure 2 denominator because it would require fewer complexity tokens, but he inquired if immunization registries allow for a bulk upload (e.g., in the case of children receiving multiple vaccines) and how bulk vaccine uploads are counted. Sasha explained that there are differences between how bulk vaccine entries are reported versus how they are transmitted. She suggested that each vaccine dose be reported in this case.

  - Bryant shared Mary Beth's comments from the public chat: "Some EHRs send multiple administered immunizations in an HL7 message, some send a single message for each immunization, but in either case, we support measuring doses, rather than individuals." Multiple TF members and listeners agreed. Steven Lane inquired as to why doses are being prioritized over individuals, adding that this measure is meant to report across EHRs. Sasha summarized previous discussions around what data would be most useful and how it would be reported: knowing that a patient had at least one vaccine in each time period or knowing that they nine out of ten recommended vaccines. Steven stated that this measure is meant to evaluate the EMR, so the details for individuals are more local issues that do not reflect on the EMR itself. Bryant agreed with Steven but asked him to consider how the data would be used to evaluate EMRs by vaccine/dose. If there is a drop-off in a given vendor or jurisdiction, it could be an indication that there is a work process gap/transmission flaw in that particular EMR.
  - The TF decided to continue the discussion on this topic before issuing a recommendation.
- There was a previous discussion that the reporting frequency across all of the EHR Reporting Program measures should match, and a period of 12 months was suggested because some vaccinations are seasonal.
  - Sasha commented that a longer lookback period would require more client computing power to run, so she suggested being judicious with the duration of the lookback period, with 12 months preferred over 24 months. Zahid Butt commented that it the denominator is the patient, the lookback period is important; but if the denominator is the vaccine administrations and the numerator is just the reporting of the number of those transmitted, the lookback period would just add unnecessary complexity.
  - TF members discussed potential numerators and denominators and various ways of wording the recommendation. Sasha stated that, for quality reporting measures, a lookback period goes beyond the (12 month) reporting period, and TF members discussed if it was necessary to include a lookback period.
  - The TF agreed to recommend that the vaccine administered is the denominator, with a 12-month reporting period and no lookback period.
- Sasha described conversations that occurred during the pre-work meetings with the experts around various permutations of the measures and potential stratification. They decided to make the burdens as low as possible, though adjustments could be made following the final version of the measure. Also, she explained that interpretation challenges were raised around analyzing data from EHR systems.
- Bryant highlighted a change made to Measure 2. It reads "Immunization Query Response" now ("from Immunization History"), which would include immunization registries that do forecasting, history, or both to achieve bidirectional communication. Steven Lane agreed with this change.
- Bryant emphasized that public health is not solely immunization delivery and encouraged the future discussion and prioritization of other public health measures raised in suggestions made by the Public Health Data Systems (PHDS) Task Force.
- Bryant added that he would wordsmith the recommendations to capture the idea that there is also a need to tally information received in bidirectional exchange.

Action Items and Next Steps

EHRRP TF members were asked to volunteer to take the lead on each week's Domain discussions by digging deep into the week's content, presenting the draft measures, and leading the discussion on them with the group. EHRRP TF members were asked to volunteer for each domain. So far, the following assignments have been made:

- August 5 discussion of Clinical Care Information Exchange: Abby Sears and Steven Lane
- August 12 discussion of Standards Adoption and Conformance measures: Ken Mandl and Jim Jirjis
- August 12 discussion of Data Quality and Completeness Measure: Sasha TerMaat, Zahid Butt, and Bryant Karras

TF members who would like to volunteer to help lead any of these topics were asked to email Michael Wittie and to copy onc-hitac@accelsolutionsllc.com.

While the members listed above will lead the discussions, it is critical that every TF member come prepared and be familiar with the measure concepts to be discussed. All TF members were asked to be ready to provide comments, suggested revisions, and concerns in the areas outlined in the Issues Template (in Google docs).

TF members were asked to review all shared Google documents prior to each meeting. TF members who are not able to access the documents should reach out to ONC staff.

Public Comment

QUESTIONS AND COMMENTS RECEIVED VIA PHONE

There was one public comment received via phone.

Mary Beth Kurilo, American Immunization Registry Association (AIRA):
Hello good morning. First off, from the American Immunization Registry perspective, we just want to say thank you for considering this measure. We recognize that all public health measures are important, but, given what we've experienced in the last 18 months of the pandemic, immunizations really bubbled to the surface something we need to pay attention to. I support all of the conversation and thanks for letting me jump in via the chat window. I just want to really underscore the piece about the successful submission of administered doses. We want to make sure that the messages coming across to IIS are well configured, and the IIS community has done a lot to make sure we are in alignment with standards for acknowledgment messages so that we can send back messages that are inappropriately configured or inappropriately coded. So we will do everything we can on our side to make sure that those acknowledgment messages that are coming across are really meaningful and allow action on the part of either the EHR or the provider, if the message needs to be modified or resubmitted because of an error.

The other piece that I just want to emphasize (and this is really more forward-looking) is that is there an opportunity to valid or better coordinate efforts? And have some sort of validation from the IIS side? AIRA and our IIS members are more than happy to try to coordinate that, and I think that we've done a lot of work through our Immunization Integration Program with HIMSS to really look at interoperability from all sides (IIS, EHRs, HIEs, clinicians). So, down the road, if there is an opportunity or an interest in validating so of this information from the IIS side, we would be happy to partner on that. I know there are other folks who want to weigh in, so I want to say thank you so much for the opportunity to take part. We are looking forward to seeing where this all goes.

QUESTIONS AND COMMENTS RECEIVED VIA ADOBE CONNECT

Mike Berry (ONC): Good morning, and thank you for joining the EHR Reporting Program Task Force. We will be starting soon.

Jim Jirjis: Jim Jirjis here

Jim Jirjis: here

Jim Jirjis: on the call waiting to get in

Ken Mandl: Ken Mandl here

Jim Jirjis: Michael, making sure you captured us who could not verbally respond to the roll call. :)

Mike Berry (ONC): Hi Jim - Yes, I monitor and capture all task force members in attendance throughout. Thanks!

Zahid Butt: I have a question. Can you hear me

Raj Ratwani: Zahid, we can't hear you. I will call on Steve Lane first and then you.

Zahid Butt: Thx. I just called in on the phone

Abby Sears: Abby is here

Abby Sears: I would hate to see us only use gender and ethnicity

Raj Ratwani: Thanks, Abby. We will capture in the document.

Steven Lane: Is there a need to differentiate whether ALL administered immunizations for an individual are reported to the registry, or is it acceptable to count a patient as reported if any of their immunizations were sent? Early in COVID there were new vaccines that could not be reported until applicable codes were incorporated into all relevant systems.

Sasha TerMaat: Regarding the proposed state stratification, do you care about the state of the registry, the state of the patient's address, or the state of the provider's office location? Each of these have varying degrees of added complexity to the reporting.

Steven Lane: @Sasha - I think that any succesful *[sic]* registry reporting should count.

Sasha TerMaat: I think my concern is simply that while stratifying by state may seem simple, it actually has some complexity associated.

Michael Wittie: If you consider places like DC where many patients have providers in DC, MD, and VA

Mary Beth Kurilo: Provider sites report to the IIS in their jurisdiction, regardless of address of the patient.

Abby Sears: I can appreciate that there is complexity but we must build systems that mimic what patients are really doing

Mary Beth Kurilo: And just a note that some IIS function at the county/city level (e.g., Philadelphia, NYC), so a decision will need to be made to segment them out or roll them up at the state level.

Vaishali Patel: That seems complicated to stratify the numerator across states. Mary Beth's suggestion seems a good one. By provider site location.

Mary Beth Kurilo: I support Sasha's recommendation to stratify by registry/IIS.

Zahid Butt: Agree with Sasha on both points esp the first point about Vaccine Administered in the Denom *[sic]*

Mary Beth Kurilo: Some EHRs send multiple administered imms *[sic]* in an HL7 message, some send a single message for each imm, but in either case, we support measuring doses, rather than individuals.

Bryant thomas Karras MD: could you scroll to top

Abby Sears: I would really ask that we include more than immies for public health. It does not represent the important role of public health in this country

Mary Beth Kurilo: To Sasha's point, I think the criteria for "successful" submission of administered doses or successful queries may need more discussion in terms of how those are measured. If a message is inappropriately configured and/or doesn't reach it's intended target, we hope that wouldn't "count" for the measure.

Bryant thomas Karras MD: thank you Marybeth. I'll edit that in to doc

Sasha TerMaat: I added a "recommendation for further discussion" on success of messages in the recommendations report.

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

There were no public comments received via email.

Resources

EHRRP TF 2021 Webpage
EHRRP TF 2021 – July 29, 2021 Meeting Agenda
EHRRP TF 2021 – July 29, 2021 Meeting Slides
EHRRP TF 2021 – July 29, 2021 Meeting Webpage
HITAC Calendar Webpage

Meeting Schedule and Adjournment

Jill and Raj thanked everyone for their participation in the discussions.

They asked EHRRP TF members to volunteer to lead the meeting for the Data Quality and Completeness Measure discussion of preliminary recommendations. Gary Ozanich commented that this measure is cross-cutting and is listed as a future measure under the Standards domain. TF commented that this measure will be complex and suggested that it could be a placeholder for the incomplete demographic measure for public health (race, ethnicity, correctly formatted address, other address information, etc.). It has not been a top priority previously, but if it can be a way to address issues that have been raised around missing SOGI and SDOH data, it could become a priority. TF members discussed the scheduling and TF members responsible for presenting the measure to the TF on August 12. Sasha TerMaat, Zahid Butt, and Bryant Karras offered to contribute, with Sasha taking the lead.

The next TF meeting will be held on Thursday, August 5, 2021, from 10:00 a.m. to 11:30 a.m. E.T.

The meeting was adjourned at 11:25 a.m. E.T.