Health IT for the Care Continuum Task Force (HITCC)

Transcript
March 29, 2019
Virtual Meeting

Members/Speakers

Name	Organization	Role
Carolyn Petersen	Individual	Co-Chair
Chris Lehmann	Vanderbilt University Medical Center	Co-Chair
Aaron Miri	The University of Texas at Austin	Member
Susan Kressly	Kressly Pediatrics	Public Member
Steve Waldren	American Academy of Family Physicians	Public Member
Chip Hart	PCC	Public Member
Cassandra Hadley	Office of the National Coordinator	Designated Federal Officer
Stephanie Lee	Office of the National Coordinator	Staff Lead
Al Taylor	Office of the National Coordinator	SME
Samantha Meklir	Office of the National Coordinator	SME
Alex Kontur	Office of the National Coordinator	SME
Beth Meyers	Office of the National Coordinator	SME
Stuart Myerburg	Centers for Disease Control and Prevention	Acting Team Lead, Informatics
Jamie Parker	Carradora Health	Director of Health IT
Andrea Jackson	Office of the National Coordinator	SME
Carmen Smiley	Office of the National Coordinator	SME
Sherry Green	Sherry Green Associates	Chief Executive Office & Manager

Operator
All phone lines are now bridged.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Great, thank you. Good morning everyone and welcome to the Health IT for the Care Continuum Task Force meeting this morning under the high-tech. Thank you for joining us. I will bring the meeting to order by starting with our roll call and then handed over to the co-chairs Carolyn Petersen and Chris Lehmann. So, Carolyn?

Carolyn Petersen – Individual – Co-Chair
I'm here.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Chris?

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Good morning.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Good morning. Aaron Miri?

Aaron Miri – The University of Texas at Auston – Member
Good Morning.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Good morning. Steve Waldren? Not here. Chip Hart?

Chip Hart – PCC – Public Member
Here.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Thank you. And Susan Kressly?

Susan Kressly – Kressly Pediatrics – Public Member
Yep, I am here.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer

Great, thank you. Thanks, we'll turn it over to Carolyn to say a few words and Chris as well and then we will get started.

Carolyn Petersen – Individual – Co-Chair
Thanks, and good morning everyone. It's exciting to be here for another week and to continue our work on the Health IT for the Care Continuum Task Force work. Today we are going to be wrapping up our discussions of the pediatric recommendations. We will also look at some Supplemental Children EHR format requirements, and then ONC going to give us a presentation to get us started on the opioid use disorder request for information. So, we'll have some new voices and some new information today on the call. And I'll now pass the mic to Chris.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Thank you, Carolyn. Good morning everybody. As for the pediatric recommendations that we have discussed on the last three calls, there will be some interesting technical aspects we still need to wrap up, but one of the things I have personally received that is some feedback from the community, especially in regard to recommendation five. I think that was one of those that we found most challenging to grapple with. So, we'll see what the community input will take us going forward. But with that said, I'm putting in the hands of ONC to take us forward here. Thank you.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
This is Sam. Good morning. I was gonna just introduce you, Al. So, Al Taylor, a voice should be familiar to those of you who have been involved in our earlier calls. Al's going to kick off the top part of our agenda by providing subject matter expertise and technical clarifying information in response to many of the earlier questions related to standard and specific recommendations that we discussed. So, Al, thanks again for joining us and I hand it over to you.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Thank you. As Carolyn mentioned at the top, we have been looking at the different, both Carolyn and Chris, looking at several of the recommendations. There were a couple of areas we needed more information on. We do have a few people on the call today from different organizations including ONC and CDC, to maybe help field some pointed questions. But the four recommendations we are gonna cover are four, five, seven and 10; which is data segmentation for privacy immunization service, segmented axis – not segmented axis but access authority related to – this is recommendation number seven. And then the availability of specific codes for specific purposes is recommendation number 10. Are slightly out of order because we have folks on the call from CDC that can help with recommendation five.
But for recommendation number five which is synchronizing immunization histories with registries, we have consistently pointed to your existing 2015 certification criteria, which is to receive immunization history and forecasting. And this has been in place and is implemented across the Certified EHR technology, I would say very consistently. And I think the key term there is the certified technology. Those two standards allow for – they set the standard for exchange of immunization history and forecasting with state immunization registries. And that has been – I have gotten repeated sort of confirmations from both our public health folks here in ONC as well as those at CDC.

This standard is fairly – probably it is a well-implemented standard, although there are some functional problems that we have categorized this task force as implementation issues. Those implementation issues should not be construed as indicating that the standards that we have set for EHRs to exchange this history is not appropriate and even that it's not mature. Those are the case. We feel very strongly, and so does CDC, that these standards are the right standards even to meet the pediatric requirements for immunization. Although, we acknowledge the implementation issues that exist having to do in part with some variability in the immunization registries at the state level and other issues like onboarding. But I just wanted to be clear. I want to give a chance for our CDC colleagues to – I'm not sure if Stuart has joined the call?

Stuart Myerburg – Centers for Disease Control and Prevention - Acting Team Lead, Informatics
I have.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Or anybody from ONC or HHS.

Stuart Myerburg – Centers for Disease Control and Prevention - Acting Team Lead, Informatics
I have.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Okay, Stuart. I think the best thing to do, I think, would be to ask if anybody on the task force has any specific questions to clarify what I've just gone over for Stuart to answer. They have asked for time in the future for a more detailed description of the strengths and limitations of the system, and we have talked about that. I want to open up for questions from the task force.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
So, Al, if I remember right, and this is Chris, the discussion that we had about recommendation five was that number one, there's not necessarily consistent across registries about what is being forecast and that there might be discrepancies in those and that especially when it comes to being able to onboard, that this could take months for people to try to get this done. And even then, there is no guarantee, and it has significant technical hurdles. But I'm gonna pause here and actually call on Chip Hart and Sue Kressley to give us a little bit more color on the issues that I just mentioned.

Susan Kressly – Kressly Pediatrics – Public Member
Yeah, so, this is Sue, and I agree because I've been in this space doing bidirectional functionality for almost 10 years. And while this may not be the right way to advance what is an actually usable interface to improve patient care and public health; I would urge us all to think collaboratively about where that sits if it's not with this group. The reason this ended up on our list is we still hear from a significant number of clinicians in the field that this is not working for them. And so, if it's not because the technical standard is not robust and what have you, then what is the barrier and whose purview is it to advance it. Because if we have an awesome technical standard that Certified EHRs can do, but it's not making it to usable space in implementation, then we've built something awesome that no one is using.

So, I don't know what the answer is but I agree with Al in that if you read through the specs, and everybody does things the right way, and I know that we're moving towards voluntary certification on the IAS side, but it's not only exchange of data, it's the accurateness of what we see for forecasting for immunization and other nuances around that. And, quite frankly, lack of resources for state IISs to onboard smaller practices and smaller vendors in a timely fashion.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
So, Chip, did you have anything else to add to that?

Chip Hart – PCC – Public Member
Oh yeah, it just dawned on me maybe you guys were waiting for me, sorry. As usual, I concur generally, and actually very specifically, with Sue on everything she said. PCC, like OP, we've been exchanging immunization data with IMS registries for 30 years. This is something we feel strongly about, and this is something we want to have happen. And I think it's just really hard to overstate the impact of the variability of each of the states implementing this on the reality of making this a measurable feature for certification.

Sue and I would never support a pediatric certification that didn't have this in it. It's fundamental to children's health and to health in the United States and to pediatric functionality. It's just that the – pardon me; I'm losing my voice this morning. Sue and I can give everyone here an hours' worth each of vignettes about crazy things we've had to do in order to actually make this work, that is all outside the scope of what's on paper in terms of here is our standard. When you have states who will literally drop an entire batch of 50,000 immunization records because one of the kid is missing a middle initial because they don't have one, which that is a reality, it's very hard then to say to the vendors, well, you're responsible for that because at the end of the day, it's the vendors that are looking for the certification.

So, for me, it's all about finding the pathway to this, not objecting to the concept or the standards or anything like that. I'm sure I can nitpick some of the standards, but the standards themselves are not the problem. I hope that makes sense.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
And I just want to go and add to that, I think, especially when it comes to immunization, but this is a problem generally with pediatricians who are Meaningful Use reporters is on their Medicaid. We have been cursed with the fact that we 56 different ways of reporting Meaningful Use, 56 different ways of being audited, and immunization is just yet one example that you can't beautiful standards but that they get interpreted 56 different ways and you have 56 different ways immunization registries are doing with it. So, this is a general pediatric issue as it relates to the way health insurance is applied to children especially through CMS and for us for the states. So, the challenge is actually not in the standards that ONC has developed. The challenge is that you have lovely people at the state level that have different interpretations of them.

Chip Hart – PCC – Public Member

If I can add one thing to add on to what you just said , Dr. Lehmann, and this is the bane of Sue's existence as it is with us; one of the practical unintended consequences of some of this is it highlights the pain of not having the universal school form nationally. So, right now, just using one specific example, you have the school form that is about to be mandated in the state of New York that is horrifying, it actually is as bad as Connecticut, where you've got a form that is physically not designed to be filled out by a computer, and it's got non-computable fields, and no standards for completion and every school nurse can interpret the rules differently.

And a very small subset of those school forms is, in fact, that immunization record, and we have to comply in order to actually to sell a system, because at the end of the day this is about implementing, and systems don't get implemented unless someone chooses to buy them. And we have to sell a system that complies that state's school form requirement and every one of them is crazily different and we are painted into a corner of where well, we're getting certified, but that doesn't actually fix your problem. And so, that's the messy part of this. It's not an objection on our part in any way. It's just that; and again, it's not the standards that are the problem. It's the implementation on the street level.

Susan Kressly – Kressly Pediatrics – Public Member

And I would just want to add one more thing. I applaud the advancement of specifications, but one thing I want ONC and everyone to be aware of is when you implement new standards, there is a really big churn overlap period were it breaks existing functionality for a lot of people, and the INSs don't have resources to say hey, we're changing. We're putting in a new version on here if you see anything, let us know, or can we test with vendors, they don't have the resources to check with vendors. And so, what ends up happening is that our users say hey, I can't order VFC vaccines anymore because all the sudden something broke and something's in the wrong field, and I'm not allowed to send it.
And my whole thing is there should be no wrong access to getting good clinical decision support for immunizations and delivery of immunizations at every opportunity that's possible. And so, whatever efforts we can use collaboratively among this group or others to actually not move just from certification and standards, but to actually thinking about how that actually works in the real world in functionality, would go a long way to making the health of our children much better and safer.

Stuart Myerburg – Centers for Disease Control and Prevention - Acting Team Lead, Informatics

This is Stuart. I appreciate hearing all your perspectives because it definitely gives me a better understanding of some of the comments I had seen earlier. And I absolutely agree that where we need to focus is on implementation because I think as everybody has acknowledged, the standards are out there and they are mature, but the issue is how is it actually being used in the field. And so, that's why at some later point, whenever there is time, we would love to present the work we've been doing around measurements and improvement and also our EHR IAS certification and onboarding projects. Because all of them is really addressing this issue of yes, we have the standards, but we need to make sure IIS are actually implementing them consistently as that's really been the focus especially of our measurement improvement activities to try to see where the IAS really are with using the standards. And then working with them to make sure they are consistently implementing those and being able to change with EHR. So, I think we're definitely on the same page, and we would love your input on some of the projects that we have going on to see if it aligns with your thinking as well.

Susan Kressly – Kressly Pediatrics – Public Member
Very happy to donate whatever part of my time and expertise anyone is willing to listen to, to advance the cause.

Stuart Myerburg – Centers for Disease Control and Prevention - Acting Team Lead, Informatics
I appreciate that.

Chip Hart – PCC – Public Member
Yeah, ditto, and I feel like for the most part organizations OP and PCC, we feel very often like we had to fight our way in to those opportunities and so anytime anyone calls us and says hey, can you give us insight about how this works in the wild, we are eager to provide the insight.

Susan Kressly – Kressly Pediatrics – Public Member
And I would just add one more thing because there are – you can work with what's happening, but there are barriers to even entry to the connect and so we can't lose that either.

Stuart Myerburg – Centers for Disease Control and Prevention - Acting Team Lead, Informatics
Oh yeah, absolutely and that's another focus of the work we're doing.so yeah, we would love to input. Whenever there's an opportunity on another call go over a little bit in more detail what they're doing that would be great.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yes.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Thank you. This is Sam I was just gonna offer; I think that later call will be later in April and we will let people know of our plan, thank you.

Stuart Myerburg – Centers for Disease Control and Prevention - Acting Team Lead, Informatics
Okay, perfect.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
To sum this discussion up, and this is Chris, the devil is not in the implementation specifications. The devil as we see it is in the interpretation at the state level of what these standards mean. And even smart, good-willing people end up with a great variety of interpretations which has been challenging. Especially for pediatricians that might want to connect to more than one immunization registry that might be in the tri-state area of Ohio, Kentucky, and West Virginia, for example. This becomes a real burden.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Thank you, Chris. And Al, we'll turn it back to you to move it on through the remaining clarifying recommendation.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME

Okay, thank you. The next one is recommendation number four which is segmented access to information. In our 2015 certification, it's a voluntary certification for data segmentation for privacy standards, the HL7 standard, the implementation guide. However, the data segmentation for privacy applies directly only to the creation and use of the CCDA documents, the consolidated data document architecture, which is the exchange of CCAs. And the 2015 certification had a requirement; the criteria had a requirement for marking the entire document all at once. Meaning this entire very extensive document has something inside there that is marked as sensitive or marked for non-redisclosure or some other privacy and security marking. Which can be read by a computer.

We have advanced this recommendation for the data segmentation to apply to the entire document, but also that each of sections of the CCDA can be marked with this privacy, at this machine-readable privacy and security markings as well as the privacy security markings all the way down to the data element level. So that each individual entry anywhere in CCDA can be marked using these standards which are also again, machine-readable.

We have discussed how that applies to data outside the CCDA, and that was a pending question on the board. While it's true the data segmentation for privacy implementation guide applies only to the CCDA, within the implementation guide, our HL7 data standards for privacy and security markings for both access to those data elements and redisclosure of the data elements. And so, those – the implementation guide does not specify how those markings are used outside the CDA. That's that limitation if you're not using the CCDA to exchange information that segmented or marked for segmentation, then there's not a standard currently to indicate how that marking is done on the data element.

So, I just – also there was a question when we discussed this earlier on the task force as to whether or not the implementation guide indicates a particular way that a document is supposed to be marked when there should be some suppression with data. It's my understanding, and maybe we can get some confirmation from – I think we've got one or two folks from ONC that can comment on this; there's no standard that says this document has suppressed information in it which in and of itself can be a disclosure of secure information.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
I'm just gonna interrupt. If people could mute their phone, we hear someone typing, thank you.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Sorry, Al, go ahead then.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
No, it's okay. So, there was a question, I think Carolyn had asked a question like is there a standard around how we indicate that there is some suppression of information or there's some data missing because of these requirements. And the answer to that question was no; there's not a standard way to do that. This, again, is an implementation concern about how the individual EHR processes those markings handles them and then presents the data or doesn't present the data to the user, based on those markings. And so, it can be based on the particular use case for the segmentation, or it can just

be a preference by the EHR and the users. So, there's not that standard as far as that standard is concerned, that implementation guide.
And so, I think I wanna open it up to either further questions from the task force, or I think we have Alex Kontur on the phone from ONC to maybe address some specific questions or concerns.

Susan Kressly – Kressly Pediatrics – Public Member
So, this is Sue, I have a question about that, not the flag, if you will, of some of the information that's been withheld. And I understand that in itself when you made the point where we talked about it was questionably a privacy disclosure. My concern is at what point safety of patient care trumps security of data. Because what's happening starting to exchange data and we're drinking from the fire hose of data and to trust it, we are quite on the precipice of doctors just wanting to not leave anything in EHR and start over.

And I think that that is a really scary proposition after we've done on this work come this far. But to not know whether something's missing or is so that you can close exam room door and have a conversation and say there's a medication, it seems, on your medication list that I don't know about that might be important for me to make an appropriate medical decision for safe care. Would you be comfortable sharing that with me now? And here's what I can see what's missing. I really would – I get the whole privacy thing, and I would love to hear from the other people in the group about whether at some point we, as subject matter expertise, have a responsibility to make sure we're giving safe care.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Were there any other questions or comments from the task force? Can I confirm that Alex Kontur or Jen Snyder or someone else from ONC is on the call?

Alex Kontur – Office of the National Coordinator for Health Information Technology – Public Health Management
Hey, Al, it's Alex them on the line.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Okay.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Alex, this is Sam, would you like to give yourself a quick introduction. Alex will be joining us for some of the future calls FACA, so folks know. There's a proposal in the rules on the data segmentation for privacy standard, and we'll have some focused discussion on the proposal, and Alex will be supporting our work in that space as well. So, Alex, if you just wanna do a quick intro.

Alex Kontur – Office of the National Coordinator for Health Information Technology – Public Health Management
Yeah, thanks, Sam. I'm Alex Kontur; I'm with ONC's Office of Technology. I generally do standards-related work, whether that's fire, IHE. I used work in a program office with state HIE's which were doing behavioral health exchange which is how I got my exposure to data segmentation for privacy and some of the consent issues that pop up there.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Thanks, Alex, we're so glad you can support and be part of the effort. Thanks for calling in. Al, should move on to seven and 10?

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Yeah, I think unless either Alex or if there were any other questions or Alex had any comments on the concerns that, I think it was Sue, raised.

Susan Kressly – Kressly Pediatrics – Public Member
Yeah, so I have one other clarifying question, Al, and that is when you said the DS4P is not just at CDA level it's at the problem list or allergy section or the section of the CDA. Is it then one more step down the road of a specific entry in that problem list or if there's something sensitive in the problem or if it's a problem listed? I was not clear with what you said.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Yeah, it goes down to the entry level. So, the problem list is, obviously, a mash-up of all of the recorded problems. And so, each of those problems could potentially be marked for segmentation, meaning –

Susan Kressly – Kressly Pediatrics – Public Member
Got it. It ties the history of abortion but has asthma and diabetes with it. That's – got it.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
It could be as long as the history of abortion was marked appropriately –

Susan Kressly – Kressly Pediatrics – Public Member
Got it.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
– and the EHR rendered the CCDA and suppressed that in the rendering, yes.

Susan Kressly – Kressly Pediatrics – Public Member
Got it. But that's in the spec for the DS4P? I just wanna make sure it's back to that granular level but –

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Yes, it goes down to the, I would say, almost the atomic level of **[inaudible] [00:30:28]**.

Susan Kressly – Kressly Pediatrics – Public Member
So, the interesting thing becomes, right? So, that's awesome for HIEs and data exchange but when practices when a patient moves and takes their whole chart, to another place, that's a different story. But that's a beast we should probably wrestle in the future.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME

Yes. So, and again, the information can be provided but it's a matter of it can be transmitted, it can be either suppressed from compiling in the CCDA; it could be transmitted and what happens when it's received at the other end is then it has to be handled appropriately at the other end. Whether only certain people can access the information, or it's set aside into a sequestered spot. So, yes. Okay, so hopefully that covered those bases. We're gonna move now to recommendation number seven. This is kind of a short answer. Hopefully, it's a short answer.

The term of this recommendation is transferable access authority, and what that covers; and maybe Chris can clarify it I summarize inappropriately, is the ability to change access to the record based on the changing care providers or family members, custodians, decision-makers in the record. The transferable part of this recommendation or this requirement is up to the people running the EHR. So, if a person comes in, is identified as somebody who should have access, based on the local rules are, then that person becomes the person with access to a record. It's not necessarily, or maybe ever, an automatic process.

And one question that the task force raised on an earlier call is whether or not there is a computable indicator of somebody who has access. So, there are some metadata element within the identity of the person that automatically grants or prevents access to the information. And I did check with our privacy security folks. The short answer is there is no single standard. The beginning of the long answer is this sort of thing is being done in a lot of different places including the education record; I can't remember the acronym, it's the ERP's education record where there with some work on standards for automatic access control or access authority.

A lot of other places that have security access issues are doing this as well. But there's no single healthcare specific standard identified, but further work would need to be done in order to implement bringing in those outside standards in these outside fields to be used in a healthcare setting so that you could assign – it's automatically assigned to somebody who maybe newly has access authority to a record. I'm going to stop there and see if there are any questions about that and then we can possibly move on to the last one because there's not a lot to say about that recommendation because there's not a standard really that we can reliably lean on right now.

Steve Waldren – American Academy of Family Physicians – Public Member
One quick item. My concern with the combination of this item in the previous one is not one of, again, philosophy or in this case, not the full active standards, that's a problem in itself. The bigger issue is one of the user interfaces in the requirement by physicians. If we are gearing up for an electronic record where every single discrete item on that record is flaggable for what is becoming in an infinite number of levels of sharing or view. So, given that we're trying to mark different care plan members here, you might have – you're talking about literally having a problem list, potentially, a problem list with four diagnoses on it, each diagnosis being individually flagged as being available for transfer or viewing by six or eight different entities.

You might say well; it's okay for me – the pregnancy is viewable by these three but not by these four, but the late-term abortion is viewable only by this one and this different one. And what you have is a user interface nightmare. More importantly, you have a user interface result that does not actually

provide, ultimately, what you're looking for. I realize it's in our hands to create something usable and viable, but the thing I fear is that people are just going to generally do a poor job marking these things accurately and your and you're gonna end.

And so, that's my concern here. I wouldn't change the direction or the intent, or I think these things are really crucial, but absence and a real understanding of standard privacy laws, let alone the technology side of it, I think that this is gonna be a mess for a while and you're gonna have a lot of unhappy users. I don't want to continue to contribute to the death by 1000 clicks problem. So, I hope that makes some sense.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Yeah, it does Steve, and I think the summary of that is it's an understatement to say it's a complex problem because a meeting within each state or local jurisdiction, there are unique privacy considerations. And the short version of this is – I think it's a reach to expect that individual EHR is going to be able to leverage the capabilities of the HER which is sometimes very complex handling of specific data, to be able to leverage that technical capability in order to satisfy all of the privacy security concerns across the entire country, I think is a reach.

Because of that complexity, there are 56+ needs, but if you multiply each state by the different considerations including the age of consent, condition-specific privacy, really, you're right. It's not infinite, but it's a pretty large number of the different considerations, and I just think that to expect either a national standard address all of them or any EHR implementation addresses all of them is maybe not reasonable. So yeah, I agree with you.

Susan Kressly – Kressly Pediatrics – Public Member
So, this is Sue, and I would agree with that, and I don't think the EHR should be in the business of understanding all of those, but I think the EHR should be in the business of allowing the end user to make smart decisions that can be trusted and use them in the same way from when you move from your hospital system to your inventory system, to buying a new system or migrating data down the road. So. At least having a playbook so that the end user can use what they think is safe is, to me, would go a long way.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Okay. I think we should move on to recommendation number 10 which should be very short. Recommendation number 10 – let me just scroll down to it, so I'm getting it right. This is actually related to recommendation number nine which flagging or tracking incomplete preventive care opportunities. This was specifically flagged special healthcare concerns, and we had a discussion last time as to whether there should be a generic or all-encompassing flag that says this child has special healthcare needs and may have special – because of specific diagnoses or combination of diagnoses, has special healthcare needs including more intensive case management.

And we discussed whether or not there's a specific single generic flag for that versus, I think most would agree, there is a list of diagnoses that it would either combination or individually would indicate the need for special treatment. Whether it's case management or more intensive care. So, the

diagnoses that will comprise this large group of special healthcare needs kids is out there using a variety of diagnostic codes and test codes in LOINC and SNOMED and ICD 10. However, there is not, as far as I can tell, there's not a single special healthcare needs diagnostic code either in any of the standard medical terminologies we use in EHRs including those I mentioned.

It doesn't mean there can't be if the community decides that it's important to have a generic flag that says this need be paid attention to more intensively. Those codes can be developed, and there are a couple of different ideas about where they can be developed. But ICD 10 which would be reflected in a bill, is a possibility but there's not a code currently that exists. But there certainly is a very fairly straightforward process to incorporate new codes into the ICD 10 system. And I'm more than happy to facilitate connection of the community to the process in order to figure out the best way to come up that code, but right now there is none. And I'll open it up for any questions or discussions about that.

Susan Kressly – Kressly Pediatrics – Public Member
So, thanks for that information. My question is what's the fastest path to success? Right? Because longer that we don't have this, the more people make stuff up, right? There is a SNOMED for referred for care coordination or whatever, but people are using all sort of around the edges instead of trying to figure that out. Do you know how long it takes to get either of those codes set organizations to something that's adopted and deployed?

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Yeah, the total cycle time is on the order of about a year, but it also depends on when you come into the cycle. If you come in –

Susan Kressly – Kressly Pediatrics – Public Member
Well, I was worried you were gonna say three years, so that makes me feel better.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Yeah, and so to create a new code in one of those systems, it takes anywhere from three to six months up to a year or so. But I did want to say, again, that what's available now is a creation of a special healthcare needs value set which is comprised of multiple diagnoses, either in combination or individually that would indicate if a patient has one of these diagnoses, it is a special healthcare needs patient. That actually can be integrated into any decision-support process that's in place now.
So, the answer to the question of how long does it take? It's gonna depend on how you decide to crack the nut. If you want to do it with a single code that doesn't exist yet, that's the timeline. If you, instead, wanna do value set that can be added to or subtracted from then it could be implemented faster.

Susan Kressly – Kressly Pediatrics – Public Member
So, my cautionary thought for that value set, which seems like the low hanging fruit, is to – it means somebody has to continually update it as there are no new ICD 9, ICD 10, SNOMED, etc. And who makes a judgment about where something fits or not. But more importantly, I sort of think this is different in different practices based on the needs of the patients. And we talked about even some of them being social determinants of health, so, looking at a special healthcare needs or a special determinant of the health of their family member. And then that gets really squarely. So, I'll defer to

Chris what he thinks and whether we need to have a sub call about there is some subject matter experts and give us five special healthcare needs, 10 SNOMEDs, and LOINCs or something. But, Chris, what you think?

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
I think we really should put our heads together. I think this is not a bad idea. We need to flesh this out.

Chip Hart – PCC – Public Member
And I'll just add, this is Chip. I'm all on board with Sue's position here. I also want to – I think it bears little discussion to what does flagging even mean and what happens after the patient is flagged? And maybe for simplicity sake, we don't need to define that right now. But I'll speak from a developer's standpoint. You give us a list of trigger things that put a mark on a patient record. That is, in fact, the quite easy to do relative to the other discussions we've had. That's really straightforward.
The real value from this is that we're creating something that actually positively affects care because physicians are being alerted in certain places or at certain times or it's making something easier to do that they have to do manually right now. And it would be interesting, maybe it doesn't need to be part the formal document but might be really interesting to discuss how is this best actually implemented because I don't want vendors to step up and do something super cheap here which is what is happened sometimes.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
So, I hear that concern, but I believe, Chip and Sue, this is a function of – this is the if you build it, they will come. If you allow people to flag a patient with something they can determine and the challenge with flags, is that end up with a lot of different ones and that you end up running out of real estate. I'll give you an example, from a prominent EHR vendor, the flags, for example, are alphanumerically ordered. Well, if you have a flag on that patient because there is a specific billing issue; because billing might be in the alphabet before cardiac conditions. You can suppress the display of something that's way more important clinically to a clinician. And then I'm not gonna – so, the problem with the flags is that you have issues related to display. That you have issues of having to build decision support around it. But nonetheless, I believe if you successfully come up with a way for pediatricians to flag his patients, maybe even manage the type of flags to a certain degree, you're gonna get them finding a lot of value in this, and you will get them starting to implement it, and that means ultimately you can build decision-support around it. So, I think that's one of those things let's just get it done, and we'll see where this takes us.

Susan Kressly – Kressly Pediatrics – Public Member
Well, so, and Chris, and I'm just gonna push back a little bit because pushing back for my SNOMED problem was ICD code. The EHR renders already have to be certified on the ability to identify a population of patients with a certain condition and use that to build care plans or clinical decision support. So, to me, I don't want another flag that I can – I want to make it – it's an overarching problem, right? To me, it really belongs on the problem list, and how you manage it in flag patients based on that, it's a different story. Let's take this off-line and put our heads together and sit in a room and figure out what those codes would look like.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah, so, Sue, I don't want to get into a protected discussion, but for example, there is a number of flags that don't necessarily translate, for example, into a diagnosis, right? That you might want to have on the patient, and I hear you loud and clear. I think we need to strengthen the ability to create panels and lists according to things that are on problem list or on the medication list. But I think this adds an additional component that allows better management of groups of patients that might not be driven by a list. So, I hear you loud and clear. I think there needs to be an improvement in the problem list, but I think this adds value. That's how I perceive it.

Chip Hart – PCC – Public Member
Yeah, to be clear, I think it adds value. I just think there are gonna be some companies like Sue's and like ours who are already interested in what happens next and the sooner we can have a discussion, even, Dr. Lehmann, on an AAP level, not on a federal certification level, this is what these things can lead to. That will lead to more fruitful result. That's all I meant by that.

Al Taylor – Office of the National Coordinator for Health Information Technology – SME
Okay, those are the four recommendations that we had an additional follow-up that we needed to do some additional follow-up discussion. And I will turn it back over to Carolyn or to Sam or to somebody else. I'll turn it over.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Okay, thanks Al, this is Sam. I'm looking at the agenda that we have on the screen. The next item we had involved of supplemental children EHR format, and this is the process whereby we wanted to circle back and really for many of the recommendations, we identified supplemental children's format requirements where we said we seek feedback about the relevance of the following, potential supplemental children's EHR format requirements and their correlation to that specific recommendation. I don't think this will take longer, but I want to honor a time in the event it does, and I'm mindful that we have folks lined up to present on OUD and the RFI. So, my suggestion is that we circle back to this item on the agenda to ensure that we have adequate time for the 15 minutes or so presentation and Q&A and some of the framing remarks before and after. So, if that sounds reasonable to folks, that's my suggestion just for a modification for today.

Susan Kressly – Kressly Pediatrics – Public Member
Sure. Yeah, I think that makes sense.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Okay. So, now let's go to the slide that says Health IT and Opioid Use Disorder Prevention and Treatment RFI just quickly to level set. This is section 6 of the Notice of Proposed Rulemaking, addresses not only Health IT for the pediatric setting but, again, has a request for information on Opioid Use Disorder Prevention and Treatment and Health IT. We have one overarching question, and we frame this as a what your general status. In other words, in the pediatric work, there were specific clinical priorities, and then those were – and recommendations correlated to existing standards and certification for OUD.

We're not asking the task force to identify specific clinical priorities per se, but this approach that was used for pediatrics we'd like your general sense of how our existing program requirements and the proposals and the rules can support the use cases related to OUD prevention and treatment. In other words, the value of this approach in Health IT for OUD prevention and treatment. So, that can be more of a valued statement perhaps for the group.

Going to the next slide, there are several topics that are within the RFI. One is – for the NAS topic, we will have a separate subject matter expert presentation and discussion on that. Status segmentation for privacy we discussed somewhat today in the context of the specific pediatric recommendation and, again, we will have a focused discussion on that. There's a proposal in the rule on this standard outside of the care continuum section, we will go over that, and we seek your input on that.
And then the third topic of that has to do with electronic prescribing, and prescription monitoring programs really are looking at – we will have a presentation today that looks at some of the current state and available standards here. And what I'd like to do now before we kick off that presentation, I'd like to turn this over to Beth Meyers who is the Deputy Director in our Office of Policy just to offer a few framing remarks before you hear from the team on a specific scope of a project in the space. Beth, would you like to offer some comments?

Beth Meyers – Office of the National Coordinator for Health Information Technology – SME
Sure. So, first off, thanks, Sam. That was a succinct, useful intro into this sort of change of gear for the discussion. I did want to frame out for you all a little bit of just sort of some guardrails around what we're talking about today for this portion of the discussion and then having that be some context for thinking about and understanding as we move to the next discussion in subsequent meetings that would specifically address the neonatal abstinence syndrome issues and the data segmentation for privacy more broadly.

We recognize that this task force is predominantly focused on the pediatric space and that is very deliberate. Obviously, we need experts in this area. This has been an incredibly robust discussion because of the construct of these proposals we really needed to make sure we had folks who could dig in and get in the weeds on pediatric health IT and on the need for pediatric settings and pediatric care. The opioid use disorder, prevention, and treatment section of the rule is just a request for information. It is not a proposal at this time. So, obviously, it wasn't going to be in its own zone task force.
But we did want to have an opportunity for folks to kind of at least talk about how we can begin thinking about health IT that supports this fairly broad and fairly diverse use case. So, that's the reason you all have been given it because of the exercise that you've been going through in thinking about pediatric health IT and support for pediatric care because the similarity here is that there's this construct of clinical priorities and needs and the need for data to move and not wanting to create silos of data.

Some of the privacy concerns or similar. You do have this overlap of neonatal abstinence syndrome, but you also have this overlap of pediatric care doesn't happen in a "pediatric setting." And the same thing sort of applies when we're thinking about opioid use disorder prevention and treatment. It is a scope of care. It is not necessarily a specialty of care. So, for that reason, you've been given this additional task to think about an approach for this and sort of a general, as Sam mentioned, I liked I

like the construct of creating a sort of value statement or recommendation around the value statement of adopting or applying aspects of the exercise you've been going through, so pediatric space to OUD.

Specifically, today, and I do want to thank you all for allowing us to sort of shift and change directions a little bit here to be able to do this. We have a presentation from some of our team that has been doing work to investigate specifically PDMPs. The scope of the project that our team will be covering for you today does include looking at some other health IT impact factors or what is happening in different states. But there's a huge focus on PDMPs right now universally. We've seen the PDMP focus in the support acts that came out last fall.

And so that project has very exclusively focused on deep dives on that area. But it does include investigating how data is moving and flowing and what different laws states have that govern how opioid data is used and can flow. So, I wanted to give them an opportunity to introduce further, but I did set the framing and context for you all, that we recognize this is informational for you and may not directly relate to something that you do in day-to-day and practice, but that that information could help you to sum the perspective of your work and in the work that you've done so far, support the conversation around what types of data elements are not available for things like neonatal abstinence syndrome.

How do the same types of use cases you consider under data segmentation for privacy need to be looked at in the same scope for this? So, it's a little bit of taking the exercise that you been through and your experience in doing that and hoping that can help us begin the construct run opioid use disorder prevention and treatment.

So, I did want to set that out for you and say that we are fully cognizant that you may not deal with the PDMP on a daily basis. However, we think that information about it could be useful in your overarching thoughts about how the work we've been through the past month or so can potentially be repurposed and, as Chris has pointed out multiple times, how it can serve as a model for other use cases specifically in this instance we're looking at this particular use case. So, Sam, did I miss anything that was on my list of key touch points?

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
No, I don't think. So, thank you, Beth. So, following the presentation on the El Paso project, also just to – I know we are gonna feel a little pressed for time. But Carmen Smiley our ONC colleague on the technical side of our shop is on the call with us today and will offer a few remarks specific to standard in this space as well. So, I just want to introduce Carmen and give folks a heads up that you'll meet a new ONC colleague and also Andrea Jackson and Sherry. So, a few new voices today and we're delighted that they are able to join us, and I want to thank them in advance for being available.

Carmen Smiley – Office of the National Coordinator for Health Information Technology – SME
Okay, thank you so much. Sam, is this where we should get started with the kickoff at the project?

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME

Absolutely, thank you.

Andrea Jackson – Office of the National Coordinator for Health Information Technology – SME
Great, thank you. Good morning everyone. Thank you all so much for inviting us to present our work to the task force. We are really excited about this project and really believe the work that we are unveiling as part of this El Paso project which we will describe will be able to be leveraged across the care continuum as it applies to many different scenarios. So, I will go ahead and dive right in.
My name is Andrea Jackson, and I work in the Office of Policy here at ONC. And we want to present to you guys some preliminary findings from the leveraging health IT and prescription drug monitoring program or PDMPs to address substance use disorder including opioid use disorder, also dubbed as the El Paso project. Next slide, please. So. as many folks know, in 2017 the Department of Health and Human Services declared a public health emergency and along with that announced the five-point strategy in order to combat the opioid crisis.

Based on that strategy, there were a number of different ways that Health IT can help with combating the opioid crisis. I won't go into each description here for the sake of time, but those approaches include enhancing prescription drug monitoring programs and improving prescribing practices, improving provider and prescriber education by advancing clinical decision support standards and functionality. Connecting and referring individuals to drug addiction treatment services which have been really important based on some of the discussions that we've had which will describe later; and improving access to more complete, accurate, and timely data and reporting which our colleagues will explain a little bit further. Next slide.

So, what we wanted to do with the project, think about different ways that Health IT can be used to combat the opioid crisis. We wanted to dig a little deeper and talk to states a little bit more specifically to understand how those approaches are being implemented across the country. So, last year in June, ONC funded a contractor led project which is the El Paso project which will wrap up in a couple of months. I can't believe that we are already closing the book on this.

But the purpose of this project was to assess Health IT and PDMP technical and policy ecosystems, again, in an effort to identify ways Health IT can be used to combat the opioid project. And this project builds upon some earlier work that ONC did back in 2012 around enhancing prescription drug monitoring and programs, and that report is available in healthit.gov for those of you who are interested in taking a deeper dive.

There are three different approaches, well, three different prongs to this project. The first one is Landscape Assessment which I'll discuss later, in which we looked at a number of different Health IT and prescription monitoring programs indicators in order to get a pulse of where states stood on a nationwide basis. We then held deep dive discussions with eight states in order to, again, gauge a little bit more specifically about some of their pain points and some the things were working really well in their efforts to leverage Health IT to address the opioid epidemic.

And finally, we took those findings from a landscape assessment and those conversations from states in order to develop a set of recommendations which we are finalizing and presented those

recommendations to a technical expert panel, much like the group that is convened here just to make sure that we were interpreting some of the different results and some of the different things that we heard across our conversations with states in order to put forth a number of different recommendations in order to advance the future states. So, as we are wrapping up this project, the anticipated deliverables include a report that outlines the indicators that we have selected as a part of the landscape assessment.
The final report with recommendations, which will not be made publicly available, but we will be sharing with our federal partners. And finally, a number of different strategies in order to assist states with implementing those recommendations. So, again, as part of the landscape assessment, we looked at a number of different PDMP indicators and Health IT indicators during the presentation today, we will be sharing with you the results of those PDMP indicators as well as the EPCS findings that we've come across as part of our deep dive with states as well as our technical expert panel.

To assist us with this project, we were working with Jamie Parker who is the Director of Health IT Programs at Carradora and Sherry Green who is the CEO and manager of Sherry Green Associates. Fantastic subject matter experts who really do bring a wealth of knowledge and expertise around PDMPs and health IT and I will turn it over at this time to Jamie Parker who will walk us through some of those findings from our landscape assessment.

Jamie Parker – Carradora Health – Director of Health IT
Thanks, Andrea. Can everyone hear me? Thank you. Thanks, Andrea and thank you, everyone, for allowing us to present on this topic. I think it's near and dear to many of our hearts and a passion project that at least myself and Sherry have been involved in for a while. And so, if we could go to the next slide, I kinda wanted to talk through a few things that we've been working on. One, in particular, is the EPCS mandate. And so, for those of you that don't know, I'm sure many of you do, but EPCS is your electronic prescribing of controlled substances.

We believe that's a critical tool that will enable healthcare providers to electronically send prescription information, particularly around controlled substances. The support act has mandated that anyone using Medicare part D for controlled substances use EPCS first of January 2021. So, what we did is we took that, and we start asking the states, as Andrea alluded to earlier, where they were in this process to kind of get a better sense of where they were in the process. And we found some barriers here. Most these barriers are not technical barriers, and I think some of what we're looking at here is more around – and this probably doesn't surprise many of you because I think these themes reoccur over and over again irrespective of which project was looking at.

But there were barriers around cost, barriers around provider education and the benefits that EPCS could bring to them. The multifactor authentication. The DEA requires authentication and the EHR system might require authentication, of which those two don't match. So, there are problems there. And then sort of multiple competing priorities. And so, when an institution looks at all the priorities that they have and they're trying to evaluate the return on investment, which ones are they picking and there's quite a few of these that are competing with each other. And so, these are some of the barriers that we heard specifically around EPCS and why there might be a lag in getting this put in place before that 2021 because, as you are all aware, that will be here before we know it in the blink of an

eye. And so, sometimes these things take a while to implement, maybe longer than a year. And we can go to the next slide.

And then as we started looking at EPCS and we started working on controlled substances, we wanted to get a state of the state on what PDMPs are. For those of you that don't know what a PDMP is, just to level set and make sure that we're all speaking the same language; I must semantic purist here; what are you talking about? What I'm talking about is an electronic database that tracks controlled substances and prescriptions for an individual. And so PDMPs, if you're not familiar, are generally systems that when a provider or pharmacy needs information about a controlled substance regarding a prescription that's sitting in front of them, they can go into this PDMP query and get information back from the PDMP about that particular controlled substance for that individual. If we can go to the next slide.

Why this is important and why this is challenging, is if you look at the PDMP and you see this as one piece of the ecosystem, you'll see here that there are five different components that come into that PDMP realm. And I kinda liken this to if I were to give every single one of you five Legos and I was to tell you to build me something, the odds are likely you'd all build something for me, but it wouldn't all look the same. And while that's a silly example, it's actually what we're finding out industrywide – or not industrywide, but statewide, that while there are these five components of the PDMP, how they're implemented, which pieces are implemented, looks very different state to state. And so, we don't really have a standard way of how all of these components working together represent an overarching picture of which each state is doing.

And so, I think, one speaker, Chris, I hope I said this correctly; said something about the devil is in the interpretation. Yes. So, we're starting to see the interpretation and what interpretation and what pieces and parts mean to individual states. And how those interpretations, and I'm stealing some of Sherry's thunder, what those interpretations mean and how they work to move this forward or in some cases, sit us in this little bit of a quandary. If we can go to the next slide.
One of the really important parts of all of these PDMP components and how this works, is there are various ways in which a provider or a pharmacy system can access the PDMP data. Generally, the PDMP data sits in a separate system that has to be queried, sometimes you have to leave your EHR or your pharmacy system, go to a different system, log in, query be information, look at what you're doing, see that okay, I have a patient here, John Smith, oh boy, and there's 400 of them. Figure out which of the 400 it is, walk back into my exam room, log back into my EHR and then have a conversation with John Smith.

So, that's one way, that's a portal to the PDMP, you can get that information. We find people don't generally like that so much. It's a many, many step process. So, there's another way you can do that. Some of your major vendors have now integrated access to the PDMP within the EHR vendor system. The state HIEs can go directly into that system or a pharmacy dispensing system. So, there are ways in which this can be integrated into the workflow depending on what vendor systems you use and how you set it up within your system.

However, when we use the word integration, I think people have lots of different definitions for what integration looks like or what it could mean. And so, when we talk about integrating that information into a clinical record, and then we lots of conversations about what that means for privacy. Al, you talked about data segmentation for privacy, this comes up quite a bit in this particular conversation. But there are varying degrees of integration. So, if it's integrated into your workflow, you can log into your HER system, and you could have something that looks like a blue button or a thing that says push here for more information. You click on that button, and it executes a query for that patient. We call that a single sign-on ability to do it so, not fully integrated but it's actually in the EHR, so you don't have to log off the EHR and go somewhere else.

A second way to do it, and in some states, they have been able to do it so seamlessly that a provider doesn't even know they're actually querying the PDMP, it's already in the clinical record. You log into the HER, the information is there, it's been placed where the state allows it to the placed in the clinical record of the patient that your treating. So, there are a couple of different ways that integration can happen, and states define integration in 50 different ways. And so, that's when the areas that we're finding is what does integration mean to you how is your state moving that direction.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Let me correct you there. It's 56 different state ways because of their state and **[inaudible] [01:14:03]**.

Jamie Parker – Carradora Health – Director of Health IT
Right. And jurisdictions, some of which don't have PDMPs which we've all looked at that as well. Is that Chris?

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yes.

Jamie Parker – Carradora Health – Director of Health IT
All right. Thank you, Chris.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
It's a horse I like to keep beating even though it's dead.

Jamie Parker – Carradora Health – Director of Health IT
I like it, so thank you for pointing that out. I appreciate you pointing that out to us. Yes, we did look at this as part of the landscape assessment. We looked, we call it, the 56 jurisdictions. So, we looked at the states and all of the territories including Washington DC so that we can get a really good sense of what's happening across the spectrum here. And I think. Hopefully, that's me – if we could go to the next – yes. I have one more slide. So, I did allude to this. And, again, this is recurring themes are can hear over and over again. You've already heard from previous speakers on different topics on this call, what the integration looks like.

So, we talked about the degree of PDMP integration and what that looks like, what providers might need, and pharmacy dispensers, what might need to happen to make the integration possible. We do

have one vendor, in particular, that has been able to at least in 38 jurisdictions, at least one entity or one hospital system in those 38 jurisdictions have the ability to integrate PDMP data directly into the workflow. So, we do have progress being made on that front with the one particular vendor. In a lot of cases in those jurisdictions. there more than one entity. But it's very difficult to figure out who that is on a review of secondary sources.

I suppose if we went to every single state and started questioning every entity within the state and really diving deep into that, we could probably get better numbers. But at a high level on a review of our secondary sources, which is what our landscape assessment is focused on. At a very high level, we know that 38 jurisdictions have some sort of solution that integrates either directly in the workflow or as a single sign-on blue button capability within that workflow and one entity within that jurisdiction. An important takeaway point here is that their support, not to borrow terms here, there are legislation acts out there that support this activity, and that is really putting the focus on this activity. Obviously, the first one is a support act, and within that support act, there is a section regarding Medicaid partnerships. And in the Medicaid partnerships if you Google Medicaid partnerships, and you look at section 1944, it will talk about qualified prescription drug monitoring programs and specifically what that should look, what is mandated as part of that, and then how that can be integrated within your clinical systems.

So, there is quite a bit of activity, and it's not like we're just dreaming this up. There are actual acts out there helping move this forward. And as such, moving this forward. I would like to toss the baton to my lovely colleague, Sherry, who is going talk specifically about how some of this interpretation and integration, some the work we're doing specific around acts and policies are playing out across the states. So, Sherry, I'm going to turn it over to you.

Sherry Green – Sherry Green and Associates – Chief Executive Officer and Manager
Thank you, Jamie, and hello everyone. If we could go to the next slide, please. As part of the El Paso, what we wanted to do is examine the extent to which PDMP statutes and regulations either support or present a challenge to various levels of integration that you heard Jamie just describe. And what we found so far is that there are 18 states with statutory, regulatory language that can allow placement of the PDMP data or the PDMP report in a medical record, depending upon a particular interpretation of the agency.

Now, of these 18 states, we found that some of the languages actually is specific to a specific category of the practitioner. For example, in Mississippi, the language is very specific to the licensees of the medical board. Now, in looking at these 18 states further, we found that seven of the states have statutory, regulatory language that applies to access user disclosure policies that normally govern the medical record to the PDMP data or the report in that medical record.

But in looking further to statutes, what we also found is that there are 14 states do that have language now that actually support and allow PDMP integration interoperability with Health IT systems, but the language is completely silent when it comes to placement of the data. So, in these particular states, and you can see them on the screen there, we're actually completely dependent on the legal

interpretation of the PDMP agency. Unfortunately, these PDMP agencies have not necessarily made these interpretations public, and they are different in the way they're interpreting their statute. Now, when we begin to look at the use of PDMP data for clinical decision support, we found that there actually is no state that bans the development or use of interpretations of PDMP data like risk score, which is common these days. But what's interesting is that even though no state bans it, we discovered that many of these risk score tools are actually proprietary. So, the algorithms are completely undisclosed.

And as a result of that, what we're that some states, like Kentucky and Virginia, are starting to issue legal opinions that the review of a risk score or a similar interpretation will not constitute compliance with a state mandate to check the PDMP. So, taking all of this information, we're actually in the process of developing recommendations now in El Paso regarding the storage of PDMP data in the medical record. And the goal here is that these recommendations that allow for the more efficient conduct of medication reconciliation. It also allows practitioners to substantiate clinical decisions and we would strive for improved coordination of patient care and improved data analysis for clinical decisions support. Next slide, please.

So, in digging a little bit deeper to look at access roles, we discovered that both in terms of the number in the types of roles, there is significant variability among the jurisdictions. And you can see there that in one state, we found as few as eight roles and yet in another state we found as many as 25 roles. So, all totaled, we identified 63 access roles across 53 jurisdictions.

Now, as you can probably understand, anytime there's a variability you're gonna end up with a lack of consistency in the definitions and this we see from state to state. The lack of consistency in the definitions, as well as the criteria for these roles, is presenting a significant challenge in terms of interstate data sharing. For example, a prescriber delegate in some states has to be a licensed healthcare professional. In other states, an office manager with proper training can serve as a delegate.

One of the more concerning aspects of this is that there's actually only 17 state PDMPs that have indicated there are allowed to disclose the PDMP data to SUD treatment providers. So, we have a situation where a provider can have significant gaps in the prescription history for a patient because she may be unable to access the PDMP data even in her border state. Next slide, please.

So, following in the theme of interstate sharing, we did identify that there are currently two hubs being used by jurisdictions for interstate data sharing. The first one is PMP InterConnect, which is owned by the National Association Boards of pharmacy and you can see that there are a majority of states, 47, that are currently showing data through that particular hub. There is a second hub called RX Check which is owned by the Bureau of Justice Assistance. And we currently have four states, Kentucky. Illinois, Utah, and Washington State that are connected to RX Check, but we do have 29 additional jurisdictions that have either expressed interest in or are actually in the process of connecting RX Check. So, interstate data sharing, sharing among jurisdictions remains a top priority state. Next slide, please.

So, to wrap up, we are in the process now, after we are giving all these highlights to you which we appreciate the time to do so; we are actually working on finalizing the deliverables that you heard Andrea speak to a little bit earlier, and along with that, simultaneously, we're exploring opportunities to be able to further collaborate with our state stakeholders as well as ONC federal partners on how to combat the opioid epidemic. So, we want to thank you again for sharing these highlights with you.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Thank you. This is Sam. I'm mindful we probably need to pause for public comment and then hopefully carve out a few minutes for some comments from Carmen Smiley. And then, of course, ideally, we'd have time for Q&A. So, I'm gonna defer to Cassandra on how to best utilize the last few minutes.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Yes, if we could open the line for public comment now.

Operator
If you like to make a public comment press *1on your telephone keypad and a confirmation tone will indicate your line is in the question queue. You may press *2 if you would like to remove your comment from the queue. For positions using speaker equipment, it may be necessary to pick up your handset before pressing the * key.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Do we have any calls into the line for public comment, operator?

Operator
No public comment at this time.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Sam, we could go ahead. Thank you.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Okay, thank you. Carmen are you on?

Carmen Smiley – Office of the National Coordinator for Health Information Technology – SME
I am.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Great, thank you. We were a few moments. I definitely wanna give you an opportunity to talk about the script standard and then if there are any remaining minute or two, if there's Q or A, we may be able to identify that and address it at the top of the next call. Thanks, Carmen.

Carmen Smiley – Office of the National Coordinator for Health Information Technology – SME

Okay, sure. Thank you. This is Carmen Smiley and an IT Specialist in the Office of Technology at ONC. And what one of my main focus areas at ONC is that I oversee all of the electronic prescribing certification testing and support around our electronic prescribing efforts and, of course, support my colleagues on the line in their opioid-related efforts because it's related to electronic prescribing. But one of the main pieces I just wanted to quickly speak to, is the industry move from the MCPDP script standard from 10.6 to 2017071. And the script standard allows for, generally speaking, the exchange of prescription information across the entire ecosystems. So, between EHRs and pharmacies and prescription management systems, and PDMPs.

And so, how this is realized in a PDMP is it allows for the integration of the prescription data, prescription history data, directly into the EHR. And you can see that the movement or rather the upgrade of the standard from the old standard to the new standard; which will, as we have proposed in our MPRM, also to be adopted, may be adopted, into the ONC certification program to be used for our new certification requirements for electronic prescribing software in the future.

Also support pediatric cases specifically, speaking to my audience. And so, one of the ways in which it does that is it ensures that the accuracy of the capture and exchange of say weight and height of pediatric patients to support weight-based dosing. It also supports compounds of medications. It also supports drug allergy checks and any other adverse events data capture and exchange to ensure that everybody, whether it's a prescriber or dispenser, understands any events that have happened in the past so we can make informed decisions and also any other clinical decision support surrounding that. And there is a number of other advantages, but the primary advantage is, of course, the accuracy of the prescribing data to support the safety of the exchange and ingestion prescription information. I know are very close to at the time and I'm sorry we haven't left much time, but if anybody has a quick question, we are all available.

Susan Kressly – Kressly Pediatrics – Public Member
So, this is Sue. I just have a quick comment. Clearly, lots of this is all over the place and good efforts. But I want to remind people it's not a problem for just that end. It's a problem for EHR vendors to try and implement this. Again, it's the IAS all over again. How do we implement this when we have users in 50 different states or 56 different regions that we have to support different rules and different regulations based on where the user's login is, and many of our practices practice in border states, and we have to figure out how do we comply when they're seeing a patient in their New Jersey office and when they're seeing a patient in their Pennsylvania office, and any standardization would be very helpful.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah, and just to echo that, it would be nice if, from a federal level, if we can have a minimum viable data set and viable standard that then states can extend on but at least you have a core that is common across all different 56 state and territories. And I think we are at the hour, right?

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Yes, it looks like we are.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Yes, we are.

Susan Kressly – Kressly Pediatrics – Public Member
This is Sue. I will be out of the country next week, and I won't be able to make the call, but I'll comment on the Google Docs.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Thank you. Stephanie, do you wanna just give a heads up for next week agenda or did we have a work plan slide we wanted to quickly share with folks? Or any other clarifying comments before we and the call-in terms of process?

Stephanie Lee– Office of the National Coordinator for Health Information Technology – Staff Lead
Hi, this is Steph. No, I think we're good to close out today. Next week we'll follow along with this discussion again. And then hopefully we will have most of our SMEs available again for any other questions and follow-ups next week. Thanks.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Thank you. And I would, just for folks who were not able to address the supplementals today; we can do that next week. Please just go through the pediatric technical worksheet, look at those supplemental children's format items that correspond for each recommendation and if there is one that you believe strongly is not correlated or relevant to recommendation and should be removed, please be prepared to offer that so we can officially work through that part of the agenda item from today's call. Thank you.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
All right. Thanks, everybody.

Samantha Meklir – Office of the National Coordinator for Health Information Technology – SME
Thank you.

Susan Kressly – Kressly Pediatrics – Public Member
Thank you.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Bye-bye everybody.

Cassandra Hadley – Office of the National Coordinator for Health Information Technology – Acting Designated Federal Officer
Bye-bye.

[End of Audio]

Duration: 91 minutes