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October 24, 2016

Philips Wellcentive comment
ONC 2017 Standards Advisory

Philips Wellcentive appreciates the formation of ONC's annual standards advisory and its public comment period as important elements of advancing this critical aspect of data exchange, born out of the agency's Interoperability Roadmap.

Overall, given the sometimes contentious perceptions of the state of interoperability within the industry and found within language of the House 21st Century Cures bill, for example, along with examples of arguably arbitrary timelines for "widespread" or "national" interoperability found also in Cures and within the MACRA legislation, we believe the Office of the National Coordinator should utilize the annual standards advisory as a standards requirement vehicle versus that of a list of recommendations.

Historic standards variations coded into proprietary health IT systems even prior to the HITECH Act continue to cause integration lags. In our opinion, "data blocking" is as much a result of legacy development as business practices.

ONC is the agency that can pursue the requirement and enforcement means to effectively advance standardized data exchange, and still do so through collaboration with the private marketplace.

To this end we regret the 2017 advisory's language around eliminating designations of "best available" standards as a pulling back from the agency's mission. We are not calling for a mandate but a consensus-driven set of standards that cannot be dismissed as a mere federal exercise. To that end, while excluding best available within the specification categories, we do note the advisory's introduction language notes that the purpose of the advisory is "to provide the industry with a single, public list of standards and implementation specifications that can best be used to fulfill specific clinical health information interoperability needs."

As the all-payer movement to value-based care expands and as quality reporting is increasingly addressed and scored at the population level, the health IT industry is moving beyond EHR data exchange to more automated and scalable data aggregation, quality, analysis and reporting platforms.

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ONC must understand and keep pace with this movement and address how efficiencies in data exchange standards can become truly standard.

As detailed in a 2016 EHR data integration survey published by Health 2.0 and linked here, health IT vendors found a very mixed landscape of success in terms of integration with legacy EHRs.

This is noteworthy because these integration efforts were conducted through APIs, roundly seen as a solid advancement for interoperability. We don't disagree with that, and the greater point being if API technology is to fulfill its promise, now is the time for clear and required standards. Likewise a recent KLAS study also discussed interface challenges among disparate legacy EHRs.

As an example within the agency's 2017 standards advisory we see variations allowing the use of LOINC or SNOMED, for example. For Philips Wellcentive, as we currently aggregate data from more than 3,000 established interfaces with more than 150 vendors, we find that a good 50 percent of the data we aggregate is custom in its origins, meaning we need to conduct normalization processes before the data can be uniformly used for quality reporting and other means. We have no issues with utilizing LOINC or SNOMED, and would have less issue with one. In instances of any acceptable combination or options – which we don't recommend – and in lieu of a "best" available, articulating specifications to use cases to avoid overlap in that regard could be beneficial.

In addition, as standards need to be crystalized, ONC needs to address the growing need for care management and population health management use cases that should be matched, to again not only keep pace with but to anticipate the ubiquitous future of value-based care and then population-based payments, either condition-specific or comprehensive, which appears on health IT framework roadmaps recently submitted to ONC.

This calls for, in part, an expansion of the voices and participating health IT firms within ONC standards and policy committees.

Detailed advisory specification comments

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- **CPT/HCPCS in combination** – We seek clarity on the agency's reasoning for the use of CPT/HCPCS in combination as a standard. If the advisory here implies there are different or better cases to use different types of HCPCS or different levels of CPT codes, we, and the industry, would welcome such designations. Overall we would refer to our above comment on ONC's mission to pare down clear and concise standards matched with use cases.
- **CPT/CDT** – Here we simply believe ONC should internally address whether CPT/CDT should be both federally required – in itself a good thing – but also commercially licensed.
- **Tobacco use** – We recommend clarity in this designation as tobacco use is not solely concurrent with smoking status, and that an expansion of language is needed here to accommodate smokeless tobacco usage (chewing tobacco) and the growing use of electronic cigarettes and/or vaporized nicotine. We therefore believe that the current coding language ascribed to tobacco use as mature is in fact premature and should be addressed as such.
- **BMI and vital signs** – Here we recommend that BMI be included or considered as a vital sign to reconcile its inclusion in CCDA transmissions and more so its inclusion in the common clinical data set.
- **FHIR –** For the FHIR standard**,** we seek clarity on its designation for only certain listed content and structures. For example, we noted its exclusion as standard for receiving laboratory results. As FHIR is ostensibly a replacement for "older" HL7 standards, is ONC implying that for basic interoperability needs, such as receiving labs, FHIR is not yet ready or mature? We would also refer to our above comments on the need for care management and population health management use cases within the development or maturity of the much-anticipated FHIR standard.
- **Behavioral Health –** Here we are simply recommending that ONC begin to address standards for behavioral health data points. Behavioral health is to be included, for example, within CMS' CPC+ incentive program through certification criterions adopted by Jan. 1, 2019, or year three of the CPC+ program, according to current program language.
- **"Administrative/payment oriented interoperability purposes…"** – We noted introductory language on the agency's decision not to include "payer" transactions within the advisory, concerning cost/claims related 837/835 transactions, etc. We would note here that payers who are moving to value-based care models are also exchanging quality data using the Quality Reporting Document Architecture specification. Our point is that overall we believe ONC

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should address cost and claims transmissions, as again the aggregation of this data is part of the creation of a true longitudinal patient record insofar as the data is used for risk stratification and other analytics. We would also note that MACRA's MIPS scoring track includes cost as a scoring pillar. Increasingly, ONC and CMS should combine its internal collaborations on data transmissions and standards to again anticipate how common or overlapping data is being used by health IT platforms and health system customers complying with increasingly sophisticated payment models. As MACRA, for example, seeks to include Medicaid, Medicare Advantage and commercial ACOs, and bring in more provider types as ECs such as therapists, psychologists, nutritionists, pathologists and nurses, ONC and CMS should increase its collaborations around health IT platforms, and ONC should define and require standards that eliminate legacy variations leading to integration challenges.

Thank you for this review and as we've noted in past and related comments to ONC, we are available to assist you in any capacity regarding market/sector advancements, health IT platforms and future rulemaking.

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