

Post-Acute Care Interoperability Working Group

Weekly Contributors Meeting Summary

Time: Wednesday, 3/27/2019, 2.00pm - 3:00 pm

Location: Skype call

Dial-in: (781) 271-2020

Meeting ID: 689190240

This meeting is being recorded.

Invited Participants

- Alan Swenson (Kno2)
- Amy Shellhart (WellSky)
- Beth Connor (CMS)
- Brandt Welker (MedicaSoft)
- Cary Ussery (LivPact)
- Chris Pugliese (Brightree)
- Cindy Frakes (Cerner)
- Dave Hill (MITRE)
- Dave Lee (Leavitt Partners)
- Debi Willis (My Patient Link)
- Dheeraj Mahajan (CIMPAR)
- Doc Devore (MatrixCare)
- Donna Doneski (NASL)
- Elaine Blechman
(Prosocial Applications)
- Evelyn Gallego (EMI Advisors)
- Floyd Eisenberg (iParsimony)
- Gillian VanderVliet
(Bay Path University)
- Hans Buitendijk (Cerner)
- Hibah Qudsi (MITRE)
- Holly Miller (MedicaSoft)
- Jason Johanning (VA)
- Jayne L. Hammen (CMS)
- Jennifer Ramona
(Homewatch Caregivers)
- Jessica Skopac (MITRE)
- Joan Williams
(Lower Cape Fear Hospice)
- Liz Palena-Hall (ONC)
- Lorraine Wickiser (CMS)
- Majd Alwan (LeadingAge)
- Mark Pavlovich (Ethica Health &
Retirement Communities)
- Mark Roberts (Leavitt Partners)
- Matt Elrod (APTA)
- Michelle Dougherty (RTI)
- Rachel Lopez (NIC)
- Robert Samples (ESAC)
- Rusty Yeager (Encompass Health)
- Ryan Howells (Leavitt Partners)
- Siama Rizvi (MITRE)
- Srinivas Velamuri (Telligen)
- Sue Mitchell (RTI)
- Sweta Ladwa (ESAC)
- William Davis
(Strategic Healthcare Programs)
- Zabrina Gonzaga (Lantana Group)

Notes

1) Charter

- Discussion on the “Primary Objective” of the working group
 - Alan Swenson (Kno2) asked if the primary goal of the working group was to develop FHIR implementation guides or if the goal was to look at the use case scenario and decide on a workflow that needs to be solved that may or may not require the use of FHIR.
 - Majd understood the primary goals as defining a use case that would lead to developing FHIR IG. Holly agreed with this comment
 - Dave explained that the idea is primarily focusing on FHIR and we can talk about other ways of doing things if it is expedient, but FHIR should be the first option. This process will be iterative.
 - Question was asked: when going through use cases, should we be identifying one that would be best suited to FHIR? Or are we trying to identify the biggest pain point where direct messaging would be better?
 - Dave – it may not be the biggest pain point, but rather to show a use case that is possible, and we can build upon quickly. Healthcare is moving towards FHIR. There needs to be a way to think about how we would move towards FHIR
 - One member stated that healthcare moving towards FHIR is not a true statement, although FHIR may be a good solution for certain things. Direct messaging and query are not going to be moving towards FHIR. There are plenty of “things” on the diagram that can be done with technology that we already have solutions for.
 - Discussion of TEFCA and proposed rules and whether v2 or CCDA have a role in the future
 - Liz described pursuing an approach where we can start on the “what” instead of the “how”. A member explained that the “what” is being constrained by the “how”.
 - Raj - People work with what they have. Raj asked if direct messaging is in the upcoming rules and if FHIR is the pathway forward. Direct does seem “archaic” but would like to know if it would even be supported moving forward. One member responded that FHIR proposals include payors and patient access, but its not all FHIR.
 - One member explained that all interoperability is not going to be supported by FHIR and it is not mature enough to be the only standard to support it. Direct, CCDA etc. is not going to be struck out by the rule.
 - Should build on US Core
 - 360x via direct is being called out specially for clinician to clinician document exchange. In the primary objective, the only identified mode is FHIR and it will constrict the use case.

- There are a lot of different “how’s” and is the secondary issue to the “payload” that we want to keep moving. Majd agrees with this comment.
- There are arguments to be made on which elements of the use will be the hottest pain points. Should the focus be on the standard first and then pick a use case based on what is possible?
- If the goal is to solve a particular use, then let’s pick the use case but we should not constrain the solution with the how.
- There is concern that if we pick FHIR with a use case that is the “low hanging fruit”, but no one valued it as a high priority, then it may not apply to the use cases that really need to be solved.
- If the goal is to test FHIR in the PAC space, then the expectation is that the use cases in the diagram are going to be FHIR based. If the goal is to solve interoperability, then FHIR may not be the only solution. We should explore that we can do with FHIR in the PAC space and be explicitly clear about the goal. Dave explained that the goal is to build a solution building FHIR. If we don’t have something that doesn’t solve the problem in PAC, then we create one.
- Beth – we are trying to focus on care coordination and what can we do to support information exchange through the healthcare continuum. Creating a FHIR API is feasible and can look at one step possibly. If this doesn’t work, then we can look at alternate solutions. We want coordinated care.
- If the goal of the work group is coordinated care, then that should be explicitly stated, rather than the standard.
- In the last ONC interoperability meeting, the clear message was to track the use case and then figure out the technical solution.
- Beth - Can ADT messaged be a high impact solution and can FHIR help with this?
- Majd – suggests that we divide the charter into two phases
 1. Identify and clarify the use cases that will apply to LTPAC exchange
 2. Where applicable help create the FHIR implementation.
- Question on what is feasible, leveraging current resources versus creating new ones.
- Doc – On the kick off call, we did discuss the possibility of creating new resources and want to prove that it could solve a significant use case problem.
- Dave – healthcare is huge, and everyone is taking a shot, but not so much in PAC. All these groups need to look inward and outward to try interacting with these other groups to prevent new data siloes. The Standard Health Record is leveraging what the Argonauts have done.

- US Core R4, yet to be published, if there are things not published, then we should ask them. If there's an area that they don't address, maybe that's an area that we can draft a standard.

2) Use Case Scenario

- There are 6 different transitions that we can look on the use case scenario
- Holly Miller concerned that in the use case, the specialists are not connected to the PCP.
- We need to build out the picture one piece at a time and not get overwhelmed by the detail.
- Primary Care Provider should be receiving information from all other specialists.
- Rename NaviHealth (proprietary name).
- Use Case Options
 1. Hospital to SNF (there is so much that happens in this space). There is a need a structured med list for medication. reconciliation. There are hospital and SNF vendors that are ready to pursue API).
 2. Hospital to SNF mirroring SNF to ED.
 3. SNF to hospitals.
 4. Bidirectional hospital to SNF
 5. Hospital admission to SNF is much more controlled. The data is richer and more accurate. It is more of a problem when there is a transition from the SNF to the hospital.
 6. Need a use case for a home-based provider. There is less support from home health hospice and providers than facility to facility.
 7. The hospital to PAC transition would be the most valuable since this working group focuses on this area. If we are looking at FHIR, we should look at what industry is using. FHIR could supplement 360x exchange. We are not going to be tacking the entire workflow, but rather the workflow that is FHIR specific.
- MITRE is working on developing an API for the DEL. This would be available to the use case to use in the connectathon.
- Hospital EHRs does not have capability to store DEL information as discrete data. If I document an ADL, that is not stored as discrete data. How do we make that data accessible if it is not in a discrete fashion? Beth - Not all DEL content is going to be in the EHR, but there are pieces of the EHR data that populates assessments in the data.

3) Poll

- There are 11-14 people that can help with the deliverables, testing and testing frameworks. This will allow for subgroups and we could potentially have two groups look at hospital to SNF and SNF to ED.

- Comment that SNF PPS is moving towards to PDPM and Home health is moving towards PDGM, which may affect the resources that people can provide.

Action Items

1) Review MITRE use case

- Identify initial tightly-scoped portion to address first

2) Working Group Governance

- Charter

3) Identify liaisons for different groups including:

- Patient care working group
- Payors working group
- DaVinci Project
- Standard Health Record
- Medicaid Project
- Clinical Interoperability Council