



September 2018 Roundtable Q&A Progress for Sharing Clinical Notes: New Standards Improve Exchange for Clinical Narrative

Below is a list of panelist responses to questions that could not be answered within the time allotted in the Health Story Project's recent Roundtable. To view the entire recording of the presentation, please visit the [Health Story Project Roundtable Archives](#). If you have additional questions, please feel free to email healthstory@himss.org.

Responses from the following panelists included below:

Dave Cassel, Executive Director, Carequality

Didi Davis, Vice President for Informatics, Conformance & Interoperability, The Sequoia Project

Steven Lane, MD, MPH, Clinical Informatics Director, Privacy, Information Security & Interoperability, Sutter Health

Brett Marquard, Principal, WaveOne Associates

Liz Salmi, Senior Strategist, Outreach & Communications, OpenNotes, Beth Israel Deaconess Medical Center

Q: Is the LOINC document ontology being used with Continuity of Care Documents (CCDs), CommonWell Health Alliance, CareEquality for semantic interoperability? Is this a part of any standard work?

Brett and Lisa: HL7 took the LOINC document ontology into consideration when designing the original implementation guides that became C-CDA. There are no current requirements that systems support the full LOINC document ontology. Clinical Notes included in the C-CDA documents are recommended to use codes from LOINC. A value set of LOINC codes for Clinical Notes of various types has been established and is used in the new C-CDA templates that support inclusion of narrative note information in an exchange document. The value set of LOINC codes leveraged can be found here: <https://vsac.nlm.nih.gov/>

Q: Do you think that HIEs will become obsolete if systems can share data through these other mechanisms? (e.g. Sequoia Project/Carequality) or are HIEs a requirement in order to make these connections from one system to another?

Dave: HIEs are a part of the overall ecosystem of connectivity. For the type of connectivity that Carequality enables today, and likely going forward, they provide one path to interoperability rather than being a requirement per se. I don't think that as a class of organizations they will become obsolete, although there will, of course, be some that are more successful than others at navigating the evolving interoperability landscape, and continuing to find new ways to increase their value to users.

Q: Who do you view as the primary gatekeeper of issues of patients in transition from one institution to the next?

Liz: Patients, care partners, caregivers, and the healthcare team should ultimately work together in situations where care is being transitioned from one setting to the next. Patients and care partners are often not equipped with the background on how to facilitate these often complicated transitions, and healthcare professionals and administrators should be helpful and compassionate to make this stressful change as seamless as possible. However, the unfortunate reality is these responsibilities often fall on the patient and their care partners. I have yet to see a comprehensive "how to transfer all of your medical records" tutorial not written by patient advocates. We need to make it easier for people to get through the complicated



process of changing doctors, health systems, and insurance companies. Sadly, there may be financial incentives as to why organizations may be making it as hard as possible. Did I answer this question directly? Not really. If I *had* to choose who the “primary gatekeeper” is, I would say it is the patient, as reality is the burden falls on them.

Steven Lane: Many individuals are involved in supporting safe and efficient care transitions. It is attendant upon the care team at the originating practice or facility to support a patient in transitioning their care to subsequent/follow-up providers. In the situation of hospital discharge, this responsibility typically falls to the discharge planning staff, who will often arrange for follow-up appointments. Most hospitals have processes in place to inform follow-up providers of a patient’s discharge and to send along a summary of the hospital encounter. It is attendant upon the receiving provider(s) to seek out and review relevant information from the preceding care team and to utilize this information in developing a plan for the patient’s ongoing care. Hospital Medicine providers take seriously their responsibilities for arranging and facilitating appropriate follow-up for their patients. This is incentivized by payment mechanisms that encourage minimization of early hospital readmissions. Similarly, primary care providers are familiar with the importance of managing care transitions and often have established processes to assure early outreach to patients discharged from hospitals to assure that they receive the follow-up and support that they need.

Q: We are working on exchanging patient's "Functional Status" using C-CDA/FHIR across various care settings. What is the process involved to make that happen. Do we need to work with Carequality/Sequoia Project?

Brett: Specific use cases are helpful when attempting to exchange a specific data element/class. For FHIR, consider developing a use case for the [HL7 FHIR Connectathon](#). For C-CDA, consider presenting the use case and potential design to HL7 Structured Documents Working Group or propose “Functional Status” focus use case for a future HL7 C-CDA Implementation-A-Thon. Carequality and Sequoia Project typically use the output of standards bodies such as HL7 or IHE.

Lisa: As stakeholders come forward to propose specific content for the Functional Status section, develop guidance for inclusion of that information, and gain community consensus on its use, Functional Status information will begin to become more interoperable.

Dave: To build on Brett’s response, it’s worth noting that the joint document content recommendations from CommonWell and Carequality are meant to set a floor, not a ceiling. From Carequality’s standpoint, even while your use case was being considered by HL7, you would be free to include the Functional Status in documents you exchanged, as long as doing so didn’t take you out of compliance with a particular document template definition that you claimed to be using. Not everyone will be able to consume the field discretely - in fact, I’m not sure if anyone could consume it discretely, today - but most if not all will be able to render this information for a user to view.

Q: Do you anticipate this will be an importable area, as in reconcilable to the patient's chart as opposed to included in the CCD but not filed in an easy way to locate?

Brett: Tricky question! My experience with EHRs supporting ‘computable’ functional status is minimal. I would expect, to start, information in the Functional Status section would be read-only. Although, FHIR may be able to enable this specific data element faster.

Q: Is the eHealth Exchange Platform capable of being used as a State's HIE (Health Information Exchange) Platform?



Didi: The eHealth Exchange Network does have several statewide HIE Platforms in production. The eHealth Exchange is currently a federated network that has well defined standard specifications and operating policies and procedures to enable health information exchange. The eHealth Exchange network has HIE technology implementations in all 50 states in the US that could be leveraged as a State's HIE Platform. A listing for all production network participants can be found here: <https://sequoiaproject.org/ehealth-exchange/participants/>