July 18, 2016

Division of Dockets Management (HFA-305)
Food and Drug Administration
5630 Fishers Lane, Rm. 1061
Rockville, MD 20852

RE: Docket No. FDA-2016-D-1224; 81 FR 30540
Notice, Use of Electronic Health Record Data in Clinical Investigations; Draft Guidance for Industry; Availability

**Via Electronic Submission**

Dear Dr. Califf:

The American Society of Clinical Oncology (ASCO) is pleased to submit comments to the Food and Drug Administration (FDA) in response to FDA’s Notice of Availability of the Use of Electronic Health Record Data in Clinical Investigations; Draft Guidance for Industry.

ASCO is the national organization representing more than 40,000 physicians and other healthcare professionals specializing in cancer treatment, diagnosis and prevention. ASCO members are dedicated to conducting research that leads to improved patient outcomes and are committed to ensuring that evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans.

We appreciate the opportunity to provide comments on the draft guidance. This guidance expands upon the FDA guidance documents Computerized Systems Used in Clinical Investigations and Electronic Source Data in Clinical Investigations; the goal of the current guidance is to modernize and streamline clinical investigations through facilitation of the use of EHR data in clinical investigations and promotion of the interoperability of EHRs and electronic systems supporting the clinical investigations. Specifically, the guidance provides recommendations on: deciding whether and how to use EHRs as a source of data in clinical investigations; using EHRs that are interoperable with electronic systems supporting clinical investigations; ensuring the quality and the integrity of EHR data that are collected and used as electronic source data in clinical investigations; and ensuring that the use of EHR data collected and used as electronic source data in clinical
investigations meets FDA’s inspection, recordkeeping, and record retention requirements.

We are pleased that the FDA is working to advance interoperability between EHRs and electronic data capture (EDC) systems and electronic case report forms (eCRF). ASCO has been emphasizing the importance of interoperability across health information technology (HIT) vendors in an effort to enrich our ability to learn from the experience of patients and clinical trial participants. We also believe, as FDA notes, that greater interoperability will increase the efficiency and accuracy of research and help clinicians integrate research more seamlessly into their clinical workflow. We believe this is an important goal and are pleased that FDA is providing additional guidance to help facilitate it.

To provide some context for our comments, below we highlight some of ASCO’s efforts related to EHRs, health IT, and “big data.” We then offer some specific comments to FDA on the draft guidance, but would emphasize that, overall, we strongly encourage the FDA to coordinate with other federal agencies (e.g., ONC, CMS) and stakeholders (e.g., professional medical societies, standards-setting bodies, health IT vendors) as it proceeds with this draft guidance. The reality on the ground today is that most physicians still struggle to exchange basic clinical information across EHRs and other clinical platforms. The FDA guidance articulates an important vision for how we could seamlessly transmit information across multiple disparate platforms with potentially varying levels of permissions and important patient informed consent processes and system audit trails. We believe this is necessary, but may take significant time and effort to achieve. We strongly urge the FDA to collaborate closely with all affected stakeholders to help ensure that this vision becomes a reality.

**Background: ASCO Activities and Initiatives in Health Information Technology**

ASCO has long been a supporter of developing and using interoperability standards for exchanging health information and has engaged in a multi-year initiative to develop cancer-specific standards that promote electronic sharing of information for improving the quality and coordination of oncology care.\(^1\) In previous comments to Department of Health and Human Services (HHS) agencies, we have emphasized the opportunities that EHRs and health IT offer for improving the health care of millions of Americans. Additionally, health IT supports ASCO’s CancerLinQ platform, which aims to help oncology professionals improve the quality of cancer care at the point of care delivery and analyze longitudinal data from large groups of cancer patients.

To help foster interoperability, ASCO has previously made the following recommendations:

- Favor and promote the use of interoperability standards and specifications that will not result in additional costs for health IT end-users, that are free, and that have minimal licensing obligations;

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- Develop Fast Healthcare Interoperability Resources (FHIR) as an additional pathway toward enabling the widespread exchange of electronic health information; and
- Develop standards that are non-proprietary to help ameliorate information blocking.

In addition, earlier this year, ASCO joined members of the health care community in pledging to the HHS to commit to principles that will advance interoperability among health information systems.

As noted above, ASCO’s Health Information Technology Work Group (Health IT WG) initiated an effort in 2012 to begin developing interoperability standards for the transmission of oncology-specific information. These standards will allow any provider, organization, or vendor that uses Meaningful Use-required standards from Health Level Seven International (HL7®) to exchange information. To carry out this effort, ASCO is working with HL7, the leading ANSI-accredited, standards developing organization focused exclusively on healthcare.

ASCO’s new interoperability standard—called the HL7® Clinical Oncology Treatment Plan and Summary (COTPS)—allows providers to extract discrete clinical information and share that information with the patient, specialists on the patient’s care team, the primary care provider, and cancer registries. To date, ASCO has published two releases of COTPS.

In 2015, the Health IT WG began a new project transforming ASCO’s paper-based Survivorship Care Plan (SCP), released in 2014, into the COTPS. This project has been prioritized as a response to two requirements from the Commission on Cancer: to provide SCPs for coordination of follow-up and to provide educational information to patients. The Commission on Cancer has endorsed ASCO’s 2014 SCP for including the minimal critical data required for survivorship care. By adding ASCO’s SCP to the HL7 COTPS, implementers will be able to electronically extract information from a patient’s EHR or other clinical system and transmit it electronically. This helps providers meet CoC’s requirement and saves providers and their staff from having to manually search for the data in the SCP and send it by fax or mail. This, the third release of the COTPS, is expected to be published through HL7 in summer of 2016.

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Specific Comments on Draft Guidance

Interoperability

For the purposes of this guidance, FDA defines interoperability as the ability of two or more systems or components to exchange information and to use that information. Specifically FDA discusses exchange of information between EHRs and EDCs. The draft guidance mentions radiology and laboratory data, as well. These data are not always incorporated
into an EHR, but might be extracted from the radiology PACS (picture archiving and communication system) or the pathology Laboratory Information Management System (LIMS).

As an overarching comment, it would be extremely helpful if the FDA would work with stakeholders to encourage the adoption and use of common standards for the exchange of information between EHRs and electronic data capture systems, and any other systems, applications, registries, and databases that might need to be integrated. Although the guidance in a general way references standards, there is no mention of specific technical standards for data exchange (e.g., Consolidated Clinical Document Architecture [C-CDA], HL7, Integrating the Healthcare Enterprise [IHE], Fast Healthcare Interoperability Resources [FHIR]) or content representation standards (e.g., IHE Structured Data Capture [SDC] for form-based data, C-CDA, FHIR).

While ASCO strongly encourages the promulgation of standards, we would discourage the use of proprietary formats developed for a single type of EDC system. Without specification of standards that can be used system-wide, the goals of this guidance will fail to be achieved.

As a professional society representing oncology clinicians, we would also note that while many standards meet the needs of general care, they do not necessarily meet the needs for transmitting specialized data required for specialty care. It is for this reason that ASCO’s Health IT WG began developing cancer-specific standards through HL7. The COTPS utilizes HL7’s Clinical Document Architecture (CDA). When it is published, the third release of the COTPS will include approximately 115 cancer-specific templates that do not exist in any other CDA implementation guide including the C-CDA. Examples of cancer-specific templates in COTPS are chemotherapy/antineoplastic therapy, estrogen receptor (ER) status, and biomarkers related to breast and colon cancer.

**Use of ONC-Certified Health Information Technology**

We are pleased that the FDA recognizes that the ONC Health IT Certification Program “would give FDA confidence ... that the EDR data is reliable and that the technical and software components of privacy and security protection requirements have been met.” Employing an existing industry standard helps avoid duplication, contradiction, and overlap. We hope that sponsors will heed FDA’s encouragement to use ONC-certified EHRs, rather than develop alternate standards or a separate certification process. Sponsors and research programs often layer additional requirements beyond those specified in FDA regulation or discussed in guidance. Any steps to avoid this over interpretation would be good to avoid at the outset.

**Privacy and Security of Data**

In the spirit of avoiding duplication and overlap, it is not clear why the guidance has an additional section to address “Privacy and Security of Data.” As noted above, the section on ONC-certified EHR technology makes it clear that ONC-certification standards address the
“software components of privacy and security protection requirements.” Clinical practices are obligated through HIPAA and HITECH standards to ensure the confidentiality and security of data maintained in EHRs. Existing FDA regulations and guidance also apply to the privacy and security of clinical trial data. What additional safeguards is the FDA considering in this section? We encourage the FDA to avoid introducing additional requirements where existing requirements are sufficient.

**Data Sharing**

The guidance suggests availability of all EHR and all clinical trial data to both/all parties involved in a patient’s care and a clinical trial in which a patient is participating. Access to all data included in the EHR is not required for the clinical trial sponsor, nor is it likely appropriate. The research protocol clearly articulates the endpoints, outcomes, and data collection necessary to answer the research questions. Where data is not required from the EHR, it should not be incorporated into the research study. Attention must be paid to development of criteria specifying who needs and should have access to specific data rather than applying a blanket approach which would risk patient privacy. On a related note, the FDA may also be interested in examining the International Committee of Medical Journal Editors (ICMJE) proposal as a condition of publication “to require authors to share with others the deidentified individual-patient data (IPD) underlying the results presented in the article” (see: [http://icmje.org/news-and-editorials/M15-2928-PAP.pdf](http://icmje.org/news-and-editorials/M15-2928-PAP.pdf)).

**Audit Trails**

For EHR data gathered during the course of a clinical investigation, FDA states that sponsors and clinical investigators should ensure there are adequate methods to monitor, track, and document all changes made to information in the EHR pertaining to the conduct of the clinical investigation. We would request clarification on the detail of the audit trail required. In general, audit trails are of two general types – minimalist (tracking who made changes and when) and maximalist (also tracking every change made to data, such that the format can be reconstructed as it existed at any point in its history). While it is not clear in the current draft guidance which sort of audit trail FDA is seeking, we would encourage adoption of the latter type.

The FDA draft guidance states that, “when healthcare professionals not part of the investigation modify or correct EHR data that will be used in a trial, ensure modifications do not obscure previous entries.” We would agree with FDA that nothing in an EHR should ever be obscured or overwritten; however, it is not clear from the guidance how FDA anticipates that people not part of the trial would know they may be modifying data that will be used in a trial if they are just performing their usual clinical activities. We would suggest that data entered by a clinician or person involved in a patient’s care should not ever be altered by a person conducting or involved in entering clinical trial data. To the extent that clinical trial data may be entered into EHRs, it should be clearly separate from data entered during the course of care and recorded as clinical trial data with appropriate attribution and auditing policies applied.
In current practice, some pharmaceutical sponsors specifically forbid the use of their drug code name in clinical documentation, e.g., “patient received ABC-123 yesterday as scheduled” would constitute a contract violation. The sponsors to date have not been able to audit for compliance with such requirements as they are not given access to EHR records, and we would advise caution that any guidance promulgated by FDA discourage the use of such audit-enabling clauses, which we would argue serve no purpose.

Informed Consent

FDA states that, “informed consent must include the extent to which subject confidentiality will be maintained and identify all entities who may have access to the subject data.” We would ask for clarification on this point. Is FDA suggesting the identification of all individuals, or of all roles of staff that may be taking care of the patient (and thus have access to data) as a course of routine care, plus trial monitors, at initiation?

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Thank you for the opportunity to submit comments in response to FDA’s draft guidance. Should you have any questions please do not hesitate to contact Shelagh Foster at Shelagh.foster@asco.org.

Sincerely,

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