



Collaboration of the Health IT Policy and Standards Committees

Interoperability Experience Task Force
Final Transcript
May 11, 2016

Presentation

Operator

All lines are now bridged.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy and Standards Committee's Interoperability Experience Task Force. This is a public call and there will be time for public comment at the end of today's call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Anjum Khurshid?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yes.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Anjum.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Hello.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Jitin Asnaani?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Hi, Michelle.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Jitin. John Blair?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, John.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Cris Ross? George Cole? Jane Perlmutter? Janet Campbell? I know Janet's here.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Janet.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Jorge Ferrer?

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician – Veterans Health Administration

Good morning.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Jorge. Kelly Aldrich? Larry Wolf?

Larry Wolf, MS – Principal – Strategic Health Network

I'm on, thanks.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Larry. And Larry Garber?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Larry. Phil Posner?

Philip Posner, PhD – Patient Reviewer – PCORI

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Phil. Shaun Grannis? Ty Faulkner? From ONC I know we have Stacy on the line; is there anyone else from ONC on the line? Okay, with that I'll turn it over to you Jitin and Anjum.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Thank you, Michelle. Good morning everyone, this is Anjum Khurshid. First of all, let me thank the ONC team who helped us bring together a very distinguished panel for the hearings at a rather short notice, so thank you Michelle, Stacy, Doug, Kim and others. I thought the panel members were very well prepared and raised many important and some new topics that we had not focused in our discussions so far, so. And I also wanted to thank all of you, as members of the task force, for participating and also asking probing questions, which were very helpful.

So overall, I think the discussions were great and you will see the summary of some of the points that were captured by our team on the slide deck that was circulated before. However, we don't propose to go through these slides one-by-one, rather we'll move quickly into the main discussion on how to integrate what we heard at the virtual hearings and some of our prior discussions to move towards specific recommendations for the joint committee.

There are a couple of things that I'd like to note before we move into that discussion with the matrix that was also sent out. We realized that we have probably one more meeting before we have to present our preliminary findings to the joint committee in June, which does not give us too many opportunities to get input from your expertise on this task force; hence our emphasis on really focusing on next steps in this meeting. Also in digesting the notes from the hearings and in holding ourselves accountable to the charge of this task force, both Jitin and I were convinced that we need to...somehow make sure that we do not end up with recommendations that are just a restatement of what is in the roadmap or has been presented in many task forces and workgroups related to interoperability, that many of you have been part of, I have been part of those meetings as well.

So yes, the nuts and bolts of interoperability are important and nuts and bolts is probably an archaic example when talking of data and interoperability, but we want to make sure that we are also highlighting the interoperability experience aspect in our recommendations, emphasis being on the experiences. And one of the things I think that we heard clearly from the hearings, and many of you have raised those issues as well in the past is that despite the tremendous progress in standards and interoperability, as was mentioned by many folks in the hearings as well, especially from the HIT stakeholders, the cognitive burden on the users, that is physicians and patients, to sort out data and when...especially when there's a lot of data coming from different sources and how this information is reconciled and integrated into workflows will remain a huge challenge in the future; even if industry coalitions or vendor upgrades are able to...or HIEs are able to solve the issue of moving data from one site to another...

So the question of how to inter...how the interoperability experience will improve and some of the questions around the current experience of patients and clinicians and others will still remain. So since

we do not have to necessarily provide from this task force, we do not have to necessarily provide like solutions for each need that we highlight, we must be able to at least raise those issues that will impact the experience as part of our recommendations to the joint committees so the joint committees can take further action on them. So we want to make sure that, you know, we are not just repeating some of the recommendations of the past, but we are actually really giving some better insights to the joint committees from the point of view of improving the experience, which I am not sure is exactly the same as just improving interoperability because I think there's the human part of that as well, which is very important in the experience.

So as one of the, I think presenters had said in the hearings, and both Jitin and I agree on this is that when we really think of true interoperability in healthcare, that means that clinicians and patients do not have to think about interoperability and that it allows them to perform their tasks in a better and more efficient manner.

So our focus in this meeting is, therefore, to try to identify and prioritize those needs that will improve the experience. And also to start transitioning from the discussions that we have had so far, which is really highlighting the needs and the needs framework with use cases to moving to what we heard in the virtual hearings and what we know from our own experiences of where the solutions are available and where they are not. So that discussion will be led by Jitin, but before I hand it over to Jitin, I would open this to any comments from the task force members regarding the virtual hearings or some of the thinking that I just presented?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Hey Anjum, this is Jitin here; I'll add something on top of it.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Sure.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

And it's more just anecdotal, so for other task force members, Anjum called me yesterday and said, "Are we really aiming towards what we said we'd aim towards when we started this workgroup or were invited to this task force? And are we really focused on the interoperability experience as we should be and is that different from interoperability?"

And I think that is still an open question, but it did remind me of a previous life in which I consulted with financial services institutions and e-Commerce companies who are trying to work with each other and try to figure out how do you create a better experience for a consumer who's using the consumer Internet, you know shopping on Amazon or, you know using the search engine and so on and so forth and the experience that leads them in that case to shop more as opposed to what we're doing in healthcare. And it reminded me that the interoperability experience and the consumer experience in general is really a function of two things; it's proportional to the delight of the end user and inversely proportional to the perceived friction that the end user has to go through to get to that outcome they want.

So in our world of healthcare, you know the relevance and timeliness of an insight or the surfacing of data which you needed or and either knew or didn't know about relative to the effort you have to put in

to get it, the number of connections you have to make, the number of contracts you have to sign, the number of steps and clicks and workflow changes and all that jazz. There is something there that is actually more relevant to the experience of interoperability that we should make sure we don't lose as opposed to sort of the nuts and bolts of getting interoperability to work. And so, I'll just really emphasize that point as well.

When Anjum pointed that out, it was like, yeah, that's right, we...as we now move towards what are some of the problems to...what are some of the solutions that start outlining where ONC and future task forces should put specific efforts, that's what we should keep in mind that it's not just about getting the nuts and bolts, and in fact, in our case as a task force actually, we should be getting our, you know we should be setting the stage for future work that is future-facing on the kinds of things which will make a big difference in a world where you don't have to think about the provider directory or the record locator service or whatever. Those are just incidental back end features that enable some experience on the front end.

So that's...at least that was my take on it and I thought it was a really good insight from Anjum that we should be using this opportunity to create that sort of future-looking, this is what healthcare can look like, interop almost...the interop experience almost becomes, I don't have to think about interop and that's really where we should be.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

And this is Janet Campbell; Jitin, I think that's a really interesting perspective and it's something that I absolutely feel like I agree with as a technologist as well, right, like that's what I'm trying to get myself prepared to do is to remove the friction and increase the delight. I think the one thing that's important for this task force to focus on though, and for ONC broadly to focus on is looking at which types of friction can be removed, not necessarily which types of delight can be added, simply because I'd rather not be part of a regulatory requirement to be delightful, because I think that would be difficult to enforce and yet something that we would probably try to do, given, you know past history.

So, I think that that's sort of a good balance for this group to look at what kind of systemic barriers can we address related to interoperability that will allow both organizations and technologists to come together to create better experiences for providers.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Jitin, this is John. Where do priorities from CMS, etcetera, payers on value-based purchasing and reimbursement reform and the drivers that they're going to be using to achieve certain things like reducing unplanned readmissions or admissions or what...you know, the things that really drive up healthcare cost. And where are those priorities in this thinking?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Hey John, I'll give you my take on it, and ob...you know, everything you subject to further shaping by, you know everybody here on the task force. My take on it is that I think at the last discussion that we had prior to the hearing, I think I see you brought up the really important point that there was...there's a whole bucket that we were missing around governance. And governance, I don't know if it's the right name for the full bucket but it includes things like training and compliance mechanisms and all of that, as well as, an important sub-bullet point called incentives which play a big role.

So we did, on the...as we...when we flipped to the matrix in a few minutes, we do have that called out specifically; it's no surprise, it was called out as high across all of our use cases that we worked on internally, or at least we suggested that its high, because we didn't actually get to discuss it since the bucket came up in the last meeting, after we'd already scored everything else. And we'll also talk about; you know what did the panelists say who were invited on that topic. I'd certainly have no disagreement that that is an important part of it. In terms of what that will lead us to recommend, that is very TBD in my mind at this point, because I'm just not sure what we'd say that's not already in the works.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Okay.

Larry Wolf, MS – Principal – Strategic Health Network

Hi, it's Larry; I want to jump in with a couple of comments. So I support the notions that there's great value from enabling infrastructure, and we heard several examples of that. But I actually have to say that my takeaway was more on the delight side and I would say the work that's being done by Healthix in New York, creating notifications based on the data they have. So where they're really trying to address the reduction in end user effort to get useful information, I feel like that's actually the kind of thing that's going to motivate people to do all the work, put in the infrastructure, and address sort of the technical burdens that are out there.

I really buy in to the statement that was made by John Kansky from Indiana Health Information Exchange that per se patient identity and data standards are not significant barriers. Obviously there's work to do to address those things, we're not perfect on those things. We have lots of examples of use makes data better, and I'm a big proponent of that. So then the question, so where were we seeing examples of use that really made the whole experience better, and I feel like the examples coming out of Healthix with their notifications are a great example of putting some computer intelligence between the data and the user and that we maybe need to be looking at more of that. And maybe the footnote on that is, and then they integrate it into workflow, so they deliver those notifications to people who find them valuable and that sort of seems like the combination of things that might be helpful.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Larry...

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yeah, I think...this is Anjum. I just think that that's a good point and one of the things that we also have to maybe focus on is, what were the things that were not highlighted that much in the hearings and some of the, I think should related to data standards and other than exchange of actual information, seemed like there were a lot of people who thought that that would not be the biggest issue. The biggest issue is really, as was pointed out, is how do you provide the right insight to people who are going to use that information.

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

And this is Jorge; I have a comment regarding the comments. I think the clinical utility for the end user and, you know we're using the words like delight, clinically speaking, you know clinicians want to be able to get their work done seamlessly, naturally, intuitively and not be burdened with workflow hindrances that are very much a part of clinical activity today. And so interoperability as has already been stated, it

should be a relatively transparent exercise, clinically speaking, for the individual but overburdening the clinicians with the workflow, the data entry, the navigational efforts and the cognitive loads for the content is not helping them.

And so I think we have to be cognizant of that because no interoperability, I mean we've just had a multi-billion dollar experiment out of the HITECH where we're still not a very interoperable nation, yet clinicians time and time again are complaining that, you know, they need to get back to clinical care and not the administrative side of clinical care, which is a lot of the data entry burdens that they're complaining about. So, I think that's something that has been highlighted in this committee and in many other committees...that we have to make note of.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Thank you, Jorge. Somebody else had a comment, too.

Philip Posner, PhD – Patient Reviewer – PCORI

This is Phil and I'd like to add on to that other one about the data entry and I'm living in the old days when people used to just dictate their notes and I wonder whether there's a way of including something like Dragon into the data entry portal, which will make it easier at the practitioner level to enter their data, rather than having to sit there with a laptop. I know when I go in for my meetings, my doctors pained having to sit there with his laptop and type everything as he's asking me questions and filling in the blanks and whatever, as opposed to just speaking it as they used to when they dictated notes.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup, so two thoughts around that actually; one is I think over here we'll continue trying to focus really hard on the interoperability aspects. There's certainly a lot to be dis...that can be discussed and explored and pushed forward in terms of the value of the EHR itself or whatever the health IT system is that the provider uses. And we'll, for the purposes of keeping things manageable here; we'll probably keep those things out of scope.

That being said, we also...we'll also just focus on those places, and this will be the trickier part of the discussion, where do we think, you know as we go through this and try to figure out what the top three five...three to five hardest problems are in interoperability experience. What are those that are largely unsolved and what's the difference between largely unsolved and partially solved or fully solved? So we'll...today we will spend a little bit of time on that because it'll be one of the data points we use as we pivot towards making, you know the set of recommendations to ONC and surface some of the insights we had from our...both our internal discussion and our discussions with the panelists.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

So Jitin, this is John. When we talk about largely unsolved, is this going to be more technical or some of these other things we're talking about?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

It'll be across the spectrum of things we figured out, John, from identify the patient uniquely to do we have the right incentive structure for enabling interoperability. As we go through our matrix we'll, you know it'll be across the bulk. And then we'll use solved versus not solved versus partially solved, etcetera as one of the data points that, you know that'll help us figure out what are the top three to five

that we really want to focus in on and recommend that ONC do something about. There's clearly, you know to Janet's point, there are things we may actually want them to do something about, things we may want them to be aware of, things may...but maybe we don't actually want them to do something about or we think it will happen elsewhere. So, there'll be a few data points that'll go into us figuring out what is this that we're going to recommend to ONC and, you know future task forces.

Larry Wolf, MS – Principal – Strategic Health Network

Let me jump in...it's Larry, let me jump...Wolf; let me jump in with a couple other quick comments. I guess I, you know I feel like we had two contrasting things so I used the example of Healthix where they were creating, you know alerts based on the data, and it seems like they're moving deeper and deeper into that.

And I contrast that with the comments from Anna McCollister-Leep who talked about the problems as a type 1 diabetic. She has access to a lot of data about herself and her insulin levels and her glucose levels and her activity; but she's really unable to get it all into one place and have it all actionable within one place for her. And it struck me that, you know here we have a well-defined population, we have a set, a data set that in many ways is sort of also really well defined and a lot of the data is quantifiable.

So I was kind of surprised that there hasn't been sort of a, you know a coming forth of tools to integrate this and make it all actionable. And so there might actually be some lessons in drilling into the specific barriers that she's run into, beyond what we heard in the hearing. So, that was sort of a surprising question for me.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Hmm, that's a really good point. This is Jitin, that's a really good point and it may well be that one of the things that we take out of this is that there's a heretofore unexplored area that we should actually be diving in, or presumably somebody should be diving into, and that's maybe a place where we bring up an...I agree Larry, there were actually a couple of places where peop...where some of the conversations went where they haven't, in the past or at least I haven't been aware of them going in the past and it might be time for, as industry kind of shifts and starts solving...and sometimes it's hard to believe, but we actually are solving some problems as a nation in interoperability. And as we do so, maybe that's part of our...part of the reason we have these task forces that spin up and spin down; we may have to revisit some of the things we do spend some time exploring now, that wouldn't have made sense, you know even a year or two back.

Philip Posner, PhD – Patient Reviewer – PCORI

Phil Posner...

Larry Wolf, MS – Principal – Strategic Health Network

So I toss out one question that struck me this morning thinking about our call, and that was you may remember the great hype around Blue Button when it first came out and some examples of, you know mobile Apps that would suck up the data and give you a useful summary. And that all seems to have gone really, really quiet and I wonder if there isn't some kind of a lesson in that for, did it go quiet because there was a level of success and people are using it? Did it go quiet because it turned out to be a very limited success and didn't get traction? I don't know why it went quiet, and maybe it didn't go quiet and I just have fallen out of the loop on what's going on with it.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, maybe all of the above in some way.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

There's a question.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Anjum...yeah, sorry I was going to ask...

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

I was just going to comment on this and say that...this is Anjum; that, and to some extent I think the Blue Button phenomena is what is being communicated by some of the members from the panel as well when they talk about, you know third parties having access to the data so they can start innovating and providing that data in meaningful ways to consumers or even to clinicians, and that probably is that bigger discussion around, you know open APIs and then third party access to clinical data which goes back to consent as well from the patient's side.

So I think there have been discussions around it, although they had not necessarily built on just the Blue Button experience, and that wasn't in, as Larry was saying that at one point I think that there was a lot of potential in terms of how we can expand that experience to almost everything and make that easy, where it could be just one click. All right, Jitin.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup, no, no that's great Anjum. Actually I was just going to ask you where do you want to...where would you like to go from here. I don't...the slides or...

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yeah, I think we...you can start at the matrix and let's see if there are any other comments.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, sure. I'm just going to share my screen, give me one moment. Sorry about that, just making sure I have this. Can everybody see this? Can everybody see the matrix?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

We can see it, Jitin.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, terrific. Is it large enough? I'm always worried that sometimes these things shrink by the time you look at it on a remote desktop. Good enough, Larry?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

It's okay.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Other Larry, good? Okay.

Larry Wolf, MS – Principal – Strategic Health Network

Yeah, if you use the option to, at least for me, if I use the option to blow it up and make it be the full display, it's perfectly fine.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, perfect. Okay, terrific. Thanks. So here's what we are going to do, you know, instead of going through and just trying to amalgamate everybody's notes or something like...or some other kludge process like that, we're going to choose a different kludge process. We...altogether we came up with...somebody might need to go on mute; I hear a lot of background noise.

Philip Posner, PhD – Patient Reviewer – PCORI

No, I had mine on mute because I'm in another conference, so I'm listening to both of you.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, I think...anybody know whose voice that was because they probably need to go on mute.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Yeah, can the operator please mute whoever that was. Thank you.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Thanks. All right. So as everybody might recall, we came up with this matrix some time ago when we went through the...each of the use cases and came up with the set of...as set of steps that were common, or not common, but all, you know the total set of steps that we would require to fulfill those use cases, and the use cases are columns B to F and the needs that we identified for those use cases are in column A.

So on the heels of the panel that we just ha...the panels that we had last week, we did a couple of things. First of all, as you go down these needs, and you know we bucketed them, and for everybody's reminder, ability to identify patients nationwide, ability to locate relevant patient records, ability to locate and identify providers, ability to access and interpret consents and authorizations, ability to encode data that is syntactically and semantically interoperable, and of course the sub-bullets call out each separately.

We actually found that on the basis of the panel, we hear...I think we heard something new which we added in here and can always move it if people think there's a different better place for it, but there is something around access and standardization of non-clinical data, such as social determinants of health, behavioral data, etcetera. Ability to exchange data including another new one we heard over the panel, ability to accept data pushed directly from patients, which I feel like should have been captured somewhere else here, but maybe I just...maybe it's a subset of 6.2 really, or I should say the first 6.2 since we accidentally had two 6.2s.

Then there was a whole new bucket that was called out during the panel, and I think Larry, you were alluding to this and certainly Anjum and I realize this as well, called the ability to meaningfully utilize the

data. To, you know to Janet's earlier point, we may or may not make a recommendation around this, but it was certainly something that came up again and again across the panels in terms of things like seemingly being able to reconcile the data; that came up explicitly several times. Surfacing insights from the data, usability and workflow, which can sort of fit over here or it can fit under our last bucket that we had created, the governance, which is a big bucket for things like user training, accountability, compliance, incentives.

So these were the buckets of needs that we had come up with plotted against the use case needs and how important they were, high, medium, low; a couple of them are blank because they came up after we did the scoring and was not immediately obvious. And what we want to do today, sorry for the total preamble, but I just want to make sure everybody kind of remembers what the spread sheet was; what we're going to do today is you know we have this high, medium, low in terms of the use case needs. It turns out not to be super-distinguishing because a lot of these are very...are high for all of the use cases and all of the use cases require almost all of them as well. So that is what it is, and that's fine.

We're also go...we're going to, over here plot whether these topics were discussed on the panel. And the point I want to emphasize is, at least for the next few minutes as we just go through this, it's not a judgement as to whether it should have been discussed or it was implicitly mentioned or so implici...you know it was implied in a discussion or anything like that. We just want to call out whether it was explicitly discussed, we all captured a few different notes and we'd like to just make sure we know what it is that the panelists chose to focus on in their discussions; whether or not we decide that we need to do something, you know, with that particular capability.

And then we won't to go line by line, because it will just take forever, but we'll use this, the information we have, what we'd learned from the discussion on the use cases, what we'd learned from the panelists, other judgement in trying to articulate what we think might be the top areas to focus on, and we'll use that as an opportunity to call out those which we know are specifically not solved, as opposed to largely solved or even partially solved.

And then depending on that, we'll probably, you know we'll, you know column J we kind of prepopulated; it might be, you know it might be entirely wrong, it might be mostly wrong, but we'll...we won't go line by line on it, we'll only spend time on the ones which we know...which we feel, you know could make the cut for the top three to five that we want ONC and future task forces to spend more time on. And maybe we'll just, you know, clear out all the rest so that there's no confusion. Okay, is that fine? Does everybody kind of mostly get it? Again, there's really no science to this, it's more, you know trying to slowly get to the point where we think we have the ri...a valuable set of insights around interoperability experience.

So here's what we're going to do; we're just going to go bucket by bucket; ability to identify patients nationwide. Across the three panels this, from the notes that I could pull out and that we, you had Anjum and I as well as the ONC team pulled out, it did not seem to be a very big focus area. Certainly in Panel 1 our panelists did talk a little bit about how to communicate with the patients, both our folks from...I forgot our panelists names, but certainly the two direct or consumer ones certainly spent some time talking about that. There was a little bit of discussion around devices, but largely those are the only places where there was much discussion. Panel 3 there was a little bit of discussion around capturing, looks like the standardized demographics, although I missed a lot of that panel because of a short conflict at that time, so maybe somebody can elucidate whether that was a deep discussion topic or

simply mentioned. Do you guys roughly agree with this, in terms of just was it discussed as opposed to a judgement call about whether...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Hey Jitin, this is John. Is it ability to identify patients nationwide or patients' records?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

No, it's about patients, the patients themselves, not their records.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Oh, okay.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, we can go on to that one next, John. So the next bucket is the ability to locate the patients' records, and there seemed to have been a lot of discussion around that on Panel 3; is that right?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Okay.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah?

Larry Wolf, MS – Principal – Strategic Health Network

So, it's Larry Wolf, let me jump in with a question. There seemed to be a recurring theme about the need for trusted networks, trusted communications, trust framework; where do you think that fits in our bulleted numbers here?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Hey, that's a good question, Larry. Umm, that is...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

I'd say under governance, but...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, I'm inclined to say so, too. Is governance missing...and thank you, thank you Larry actually for bringing that up? There may be categories as we went through this yesterday, you can see we came up with a few categories which we thought were missing altogether, and so we added them in. If there are, which from your notes things which we should be adding in, please that's actually a supercritical insight from this panel? Larry, how do you characterize this and do you agree it will be under governance?

Larry Wolf, MS – Principal – Strategic Health Network

So it could be under governance, I mean the whole notion of a trust framework typically implied that you can identify the endpoints, so it might tie in to patient identity, especially if patients are generating data that might tie in to provider identities since they'll be clearly requesting and generating information.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right.

Larry Wolf, MS – Principal – Strategic Health Network

But I think it's fine under governance, to have a trust framework might be the right word.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Trust framework. Not quite sure why the font, it looks like that, fix it up...all right, trust framework, okay. Terrific. And where was that mentioned, was that a key topic for Panel 3? I don't recall Panel 1 and 2 talking about it a whole lot, but maybe...

Larry Wolf, MS – Principal – Strategic Health Network

Yeah, Panel 3, Christina in Panel 1 talked about that.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Oh, okay.

Larry Wolf, MS – Principal – Strategic Health Network

It was in the context of nowhere for the pat...for the data to go, the patient can't say where I want you to send the data and that was her take on the need for trust...I need to tell you where to send it, you need to trust that that's okay, even though we have some interpretations of HIPAA from our friends at Office of Civil Rights saying that once the patient tells you where to send it, you're free and clear; but I don't think most providers feel that way.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Got it. Okay, that's terrific.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

So I have a...this is Anjum, I have a further clarification on the trust frameworks. Are we mainly talking about local trust frameworks or are we saying the need for like a nationwide trust framework?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

What was the and this again is really just about what the panelists discussed. What did Christina say about trust frameworks, do you recall Larry, or anybody else who honed in on that point?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

So I think...this is Anjum, I think there were two different discussions. One is, I think what probably Christina was saying was more like a national trust framework but then if you think of Panel 3, where we were talking about really HIEs a lot, I mean that's a local trust framework that has been created, but that doesn't necessarily solve the nationwide problem, in terms of identifying patients...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, okay, I got it. Is that worth calling out as two separate ones Anjum or should we just call it out and...call it out here as a, you know, parenthetically for example?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

My sense is that, you know this is fine as you have described it that we just recognize that there is a local trust framework which has been created I think in many places and there is a national which is kind of missing.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Ahh, okay.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

But they were both discussed in the panels, I think in the hearings.

Larry Wolf, MS – Principal – Strategic Health Network

Yeah, we had the implication and maybe John can speak to this that patients should be able to get Direct accounts and be able to generate, send and receive Direct messages and maybe build on that framework.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Umm, yeah, I'm not sure, I mean again you've got to...it would come probably through some commercial offering, but I agree with that if they can become Direct enabled through...because it's going to be connected to whatever platform they're using, you can't mix that...mix and match, you know have a Direct account that works on several platforms. So if they have that, certainly that opens them up to whatever it is, in excess of a million endpoints that they can connect to, but then you get into the whole workflow and trust and everything again, so.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, sure. These pieces are always largely connected together, particularly as you go from the hard infrastructural components to the softer, sort of fabric components for exchange. All right, that's fair. All right so let's come back up to the top for a second. So ability to identify patients nationwide, it sounds like nobody has any pushback in terms of...or any further notes as to where else it was discussed or the degree to which it was discussed.

Ability to locate pa...relevant patient records, much more...there was a lot more focus on it in Panel 3, sounds like there was a lot of discussion Panel 3. Showing how to retrieve the record, it seemed to have been a discussion point across all three panels. But...so that's, I think, that's what it is and let's...unless anybody has any pushback, we'll go to the next couple of buckets around ability to locate, identify providers and ability to access and interpret consents and authorizations.

So my, at least...and this struck me yester...day before yesterday as we were trying to put the notes together, I was surprised, at least retrospectively I'm surprised by how little discussion there was around ability to access and interpret consents and authorizations. And so I don't know if it was discussed in Panel 3 at all because I missed a chunk of that panel. In Panel 1, there was some discussion around it, so that's the one place where there was discussion. But it was not, you know to a particularly complicated extent, it was knowing that I could, you know I'd be able to share or send a particular piece of data to a patient's provider and have the consent for it. Did anybody else get a different set of takeaways or

something else to help us make sure that we characterize whether this was discussed or not across the panels?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

What I recall...Jitin, this is Anjum that even in Panel 1 I think this was discussed more in terms of really a need that is unsolved, from the patients perspective.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

From a patient's perspective, right; from a patient's perspective, actually that's really good. Okay. Not solved...actually I'm going to capture that so we'll see what we're going to do with...a patient's perspective, and we'll figure out how to put this together. All right, okay. Let's keep going then. Ability to encode data that is semant...syntactically and semantically interoperable; that seemed to have been a theme across and the ability to exchange data was also discussed it seems like across all of the panels. In particular I recall quite a bit of discussion on...in Panel 2 around the C-CDA, not surprised about that.

A lot of discussion around free text descriptions and explanations, I know...I recall that from both Panel 1 and Panel 2 and it was particularly in Panel 1, and I presume in Panel 3 that I missed that there was a lot of discussion around non...data that's not typically part of, you know the clinical data set, certainly not the core data set that was required for let's say Meaningful Use Stage 2 for example. And so that seemed to be a rich area of...I don't know if it's a rich area of insight, but certainly made everybody's cut to the top three or four topics that they wanted to talk about. Does everybody agree did anybody get a different impression?

Larry Wolf, MS – Principal – Strategic Health Network

So, it's Larry Wolf; I think that there was a comment about the variability of data, even within a single provider organization across departments and my takeaway, because there were then panel comments about this, was that use drives data quality. And we had some comments about the use of ePrescribing has greatly improved the data quality around medications and so I'm wondering if that isn't a takeaway that, you know I know there's a lot of emphasis within ONC and government on improved testing and better certification process and I think we're also getting a market message of, if you get use better...higher levels of use will drive higher data quality.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That als...that does jibe with what intuition and certainly my narrow experience with CommonWell would suggest. Anybody else, any thoughts or feedback on that? Larry, you always come up with one...at least one great quotable quote every time we have a meeting, thanks for sharing that one.

All right, finally, coming down to the end; again this area was...the ability to meaningfully utilize the data was an area of rich exchange. In retrospect I'm surprised we did not have this as a set of needs that we'd articulated in the first place, but it was certainly where a lo...there was a lot of focus. I think I heard the words...I think I heard the word reconciliation across each of the panels, so that's clearly still an area of pain that's...that everybody was articulating.

Certainly heard something about the clinical insights in the data, usability and workflow design, it's come up again and actually it's been coming up at almost meeting of every interop focus panel for the last five years; so, no surprise there. It's still an open discussion point that was discussed.

Governance, surprisingly did not come up as much as I thought it would in Panels 1, and apparently not as much in Panel 3, I'm...at least from what I see here myself. But Panel 2 certainly it was a big emphasis and that's, you know primarily the EHR vendors, so it's not surprising that they looked at that as a trouble point...I should say EHR vendors and other HIT vendors who were Panel 2, and all called that out as one of the more difficult aspects of interop. Did anybody hear anything different or that they'd like to add?

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

Can I ask...I have a question? On ability to meaningfully utilize the data, are you talking within a clinical application? Because you know that clearly is not the case, I mean clinicians are using the data however it's presented today. And the reason I ask is that are you more addressing the ability to...is it clinical utility or...because that's...does everybody really understand what that means on this call?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Jorge I think the answer is yes, clinical utility, but why don't you contrast that to make it more clear, in terms of clinical utility as opposed to...

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

Because, you know showing more data may or may not be relevant, but clinically speaking, clinicians want the right amount of data that's clinically, contextually meaningful volumetrically, so don't throw everything at me at once if that's not what I want. If I only want two values postoperatively, that's all I want to see, don't show me, you know six panels.

And so with regards to, you know meaningful utili...I mean, I think that that's going to get more into the discussion of usability and workflow. You know, how much data do I need to make a clinical reasoned decision based on the information that's presented and based on the information that I have acquired through an interrogation, clinically speaking. And so for me, ability to meaningfully utilize the data, I don't know what that means.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Would you suggest phrasing it slightly differently? I think the underlying spirit behind this was...comes down to, Anjum, what's the phrase that you used, the cognitive burden...

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Burden, yeah, so we're using...so from my perspective...this is Anjum. From my perspective you could also use it from a patient's point of view and say, how does the patient meaningfully use the data, how are they helped and meaningfully using that data; which means that the...one, the data are reconciled as far as possible, you know in an automated fashion so they don't have to do this. In the case of clinician probably they have more skills to reconcile it than the patient but, that's...I mean, that depends on what the application would be.

And then because the amount of data may be so large that it would be helpful for them in order to meaningfully use it, that there is the surfacing of insights from the data, so all the data is not dumped on them, which is true for both clinicians and patients, in terms of the volume of data that will be available to them.

And then finally, that those insights actually appear at points where they can actually use it, which is like the workflow and usability aspect of it. So for a patient, for instance, in the future we are looking at maybe applications that will use the data from clinical side, but also use data from their choices for food and their choices for shopping and exercise and be able to give insights to them when they are at the point of say purchasing or when they go to a grocery store so they get the right reminders in terms of what they should be buying and what they should not be buying.

So that, to me, that's the meaningful use of data for them and there are all these steps that have to take place in order to make that experience really helpful for them, so that they can make the right choices whether they are clinicians and whether they are patients or somebody else. So I think it will vary depending on what the skill level is and what the role is, but in many ways I think the steps will be probably similar.

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

Do you include the data displayed in visualization experience of the end user as part of that requirement?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yeah, I think that maybe usability will cover that, but if you think there should be a separate like visualization or...

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

Mm-hmm. Because, you know we...there are methods of taking very complicated, complex medical information and cognitively reducing the burden so that this display of the content for the patient or the clinician is more consumable, for example. That is an attribute of usability, so that's what I'm trying to get at. So I assume what you're talking about is also that you can put a lot of information, but if the recipient viewer, either clinically, the individual or the patient cannot ascertain the data that they're viewing, for whatever reason, either there's healthy disparity, they don't understand...it's incomprehensible, right, and because you know the huge gap here is the medical speak versus what's comprehensible by the patient.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Right.

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

So often times that's what clinicians do, they are brokering those differences so that people actually understand the clinical notes instead of being described. So I think it's important to make a notation that the display of the content is also a critical factor with regards to, you know, this term here, ability to meaningfully utilize the data.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

I think that's a very good point.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Hey...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

How would we articulate it or say this differently so we capture it here? Sorry, I know somebody's just got to speak, just want to make sure I capture it appropriately. Are we...should we create a separate row that talks more about the visualization aspect about usability?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yeah Jitin, I think that would be helpful, yeah, let's add another line and Jorge was like describing that really well.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

And I think there is still a separate point about workflow...

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Right.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

And this, I think across all of these is something about cognitive burden; I don't know how to capture it so I'm just going to capture it parenthetically for now. It's reduce cognitive burden should actually be the...one end of a spectrum that says, you know at the other end of the spectrum should be something that, you know gives you tremendous insight, not just reduces burden but actually enlightens you in some way. So, maybe I'll call it...I think somebody else was going to speak, was that you Janet, who was about to speak?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Yeah, I was just going to say with the original 7.3 and maybe now 7.3 and 7.4.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Umm, right now we have those as unsolved, but as Larry pointed out, there are some good examples there of how we really can surface this data and make it usable, even within a workflow. So I was wondering if that one, if unsolved is the correct designation for that?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, actu...you know, absolutely. I...the column J may be largely incorrect; I'm actually not sure, we just we took a stab, kind of put our finger in the air and said, maybe this is right. So absolutely happy to ch...focus in on understanding whether any of the priorities for us are solved or not solved. The tru...it's probably true about the rest. Just for sake of argument, I'll go ahead and change it, but we, you know we'll come back to any which we think are high enough priority for us to spend more time on.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Oh gotcha, I see. Okay, sorry, I jumped the gun on that one.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

No worries, no, that's fine, that's fine. If there's something that feels like there is a...it's just a red flag in your mind, you should always bring it up. All right, let's keep on...any...this...again, this was a bigger area of discussion, at least...than at least I anticipated and then we really had nothing to capture. Does this still capture the qualities of the discussion that was had around meaningfully utilizing the data? All right, I'm going to take that as...I'm going to take silence for a yes at the moment.

And then finally around governance; there was some discussion around governance, and again many in Panel 2 spent a lot of time talking about it. So let me ask everybody this question and then we'll have the truly tricky conversation. Can you go back to your notes, just refresh yourself, take a moment, take a look and let me know if we think we have captured all the right sort of big buckets? Is there any other...anything else in the notes that we'd want to emphasize or add in, some quality we'd want to add in here, particularly to the needs bucket or to the...or that was discussed and I've just failed to capture it over here.

Larry Wolf, MS – Principal – Strategic Health Network

So, yeah it's Larry Wolf. So I think this fits into the governance thing; so there were some comments about healthcare becoming more of a team sport. And organizationally that usually gets represented by various agreements around how organizations will work together. So I don't know...so trust framework to me is sort of the technical side of that, so I think there is like an organizational side of that and I don't know where that fits in, but it seems like that's part of making all this stuff actionable, is that the organizations actually come together and agree that they are going to partner, they are going to share information, what are the ground rules? So maybe it's administrative partnerships or, I don't know what it is.

You know, it's the thing that Carequality's trying to address with some of their agreements. It's what CommonWell is trying to address, I think. You know in some ways by pre-packaging, here's all the ground rules...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I think part of that came up in the Surescripts testimony, too where he was talking about one of the keys to their success was the relationships that the network helped build. So I could see that folding into this.

Larry Wolf, MS – Principal – Strategic Health Network

Yup.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So let's see, it's...so it's not technical, it's sort of contractual or relationship; I don't...actually I don't like the word contractual because it feels like it's...that's more prescriptive than what it's meant to be. It's, umm...

Larry Wolf, MS – Principal – Strategic Health Network

Well maybe it's organizational trust. So I know we're using trust in different ways here...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes.

Larry Wolf, MS – Principal – Strategic Health Network

...but I think that that's, you know, that comes up a lot of, you know I don't trust the data from the source, I want to know who the source is so I can assess whether it's trustworthy. I suspect it's more than just trustworthiness that they're trying to assess, but I don't know what to call it, partnerships or...

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

Larry, are you referring to the provenance, for example and I just want to make sure I understand what you're saying. So if you have a referral and a patient lands into your hospital and you're about to operate and you have to make a decision whether the information that is being received has a clinical trustworthiness or you may or may not repeat a test based upon where the originating documentation originates from, actually it's transmitted. And as you know, clinically these instances occur very, very quickly. You might be done and discharged with a patient before you even get the H&P preoperatively. And so is that what you're referring to with regards to the trust of the information?

Larry Wolf, MS – Principal – Strategic Health Network

Well I think data provenance is a really important topic that I don't think came up during the hearings, but I think is really important and I'd be happy if it showed up here. But I'm thinking more at the level of, you know healthcare provider organizations come together, sometimes facilitated by their local HIE, HIO, sometimes facilitated by an ACO, sometimes facilitated by a big purchaser, you know sort of Boeing and IBM are kind of examples that come to mind, at least for our group. And that partnership drives a bunch of activity that I think in many ways is really important. It's sort of like this team sport at the macro level.

At the patient level there are going to be a bunch of different individuals providing the care that span organizations. And when those organizations come together and say, we're going to work together, we're going to put performance improvement teams in place, we're going to focus technical resources; we're going to address the barriers that we run into because we see collective value in doing this. That feels like a thing that needs to be reflected somewhere in here, when all that comes together. And I don't know what the governance, I think it fits under governance, but that completely misses the, you know the quality that I'm trying to describe.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Hmm.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

And when you think about...this is Anjum. And so when you think about organizational...and it's not necessarily just medical facilities if you're thinking of ACOs or more a population health use case, then there are also entities like social service providers who may have to...

Larry Wolf, MS – Principal – Strategic Health Network

Yeah.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

...participate or collaborate in that.

Larry Wolf, MS – Principal – Strategic Health Network

Right, right, yeah. But it's creating that collaboration, it's creating the teams, it's baking in the performance improvement process, it's...

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Right.

Larry Wolf, MS – Principal – Strategic Health Network

...a lot of things that go from a good idea to successful implementation.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That's interest, I mean, Larry when I think of these things, especially those last few examples you gave, to me that's...those are usually indicative of a cultural change process or change management process at the least. Sometimes within the system itself, within the organization or within the community is another way of looking at it. I've typically heard of it within the health system itself...

Larry Wolf, MS – Principal – Strategic Health Network

Right.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...but within the community there's definitely a degree of cultural change you need for interoperability to happen, for example in a local community.

Larry Wolf, MS – Principal – Strategic Health Network

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Maybe you're right, maybe it sort of does fit in governance but I agree the governance/trust framework undersells the type...the nature of the work involved here.

Larry Wolf, MS – Principal – Strategic Health Network

Well, you know I'm look...we've got a heading, 8.1 effective user training.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah.

Larry Wolf, MS – Principal – Strategic Health Network

And maybe, which has been bothering me actually, but I'm wondering if it's re...if the goal there is really or the need there is user engagement or team building or the kind of change management that you're talking about, macro, large scale change management, organizational alignment; right, there's a lot of pieces in there that may bigger than effective user training.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That's right.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

I like the alignment term I think because again I think it also varies depending on what particular case you're looking at who has to be aligned...

Larry Wolf, MS – Principal – Strategic Health Network

Yes.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

...where even I think patients, patient's families and sometimes their communities have to be aligned. But in other cases it's very clinical so only the clinical partners have to be aligned. So I like that term alignment. And I would say that probably some of the discussion that Art Davidson was doing from the public health perspective and both Healthix and the Indiana HIE were doing were partially addressing some of those issues as well.

Larry Wolf, MS – Principal – Strategic Health Network

Yes.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

It's how do you align the different organizations to share information in the right way for action.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is the other Larry.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Hello, Larry.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I had a...one thing I think that we may not be...thanks. I think one of the things that we may not be capturing that was brought up by a few of the panelists was the ability to actually get the data out. So, you know even though every EHR is supposed to be able to generate a Consolidated CDA and spit it out, getting it out at the time that you need it, say at the close of the encounter and getting it to where it needs to go was something that people were paying extra money to accomplish, get out of a, you know an EHRs health information exchange and get it to move out of there to some other HISP was something again that people were having to pay extra for.

So I, you know in...you may have listed that the ability to query is largely solved, but I think that a lot of times it's not solved in a way that is hassle-free. And also it doesn't always have the data elements that you were hoping to be able to pull out of an electronic health record, just a standard Consolidated CDA, you know maybe didn't have the progress note in the CCD or maybe it doesn't have the data elements that you needed for the quality analytics. So I think we need to reflect that somewhere that that's not solved universally.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, so that's great. Let's talk about both of those two pieces; actually, other Larry, if you don't mind I want to just go back to first Larry for just a second. First Larry was, or Larry Wolf I should say, the organizational/community alignment, which panels was that discussed in? Was that discussed, according to your notes, do you recall which panels discussed it, if any? It was discussed by Surescripts.

Larry Wolf, MS – Principal – Strategic Health Network

If I include the...yeah, if I include the team sport comment, so Steve Lane whose Sutter talked about it being team sport. Umm, I could include Christina, who talked about Get Real Health and the need to bring the patients in. Umm, I'm looking at other people.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

I think it was discussed, what was it?

Larry Wolf, MS – Principal – Strategic Health Network

(Indiscernible)

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Was this part of the point Janet about...that was raised, I forgot the gentleman's name from Surescripts?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

It might have been some, yeah.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

To some ext...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I don't remember, Jitin.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, okay.

Larry Wolf, MS – Principal – Strategic Health Network

Yeah, I thought it was interesting, my notes from Surescripts talk about the difficulties of success with a centrally managed environment is much harder in a more dispersed environment, so that could be...that could easily be part of that same discussion as you bring people together.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. That's good. I don't know if anybody thought that that was...was that discussed in Panel 3 much or was Panel seemed to have focused elsewhere? Anjum, I don't know if you recall from your notes whether that was discussed.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

I thought that it was indirectly discussed because the work that both Healthix and the Indiana HIE are doing, I think are related to both the alignment.

Larry Wolf, MS – Principal – Strategic Health Network

Yeah.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

And also a technical address...because a lot of them are also NATE accredited, you know which is the trusted exchange national association.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

So I think both when you talk about public HIEs, I think that's probably an important part of that.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So my question for you is, did they actually dis...I certainly agree that it's an important part of what they provide.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yes.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

But did they actually spend any time discussing it just as an objective it was something they brought up matter?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

I don't recall specifically. I don't know if anybody else recalled it, yeah.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right, that's fine. If anybody recalls, then I'll add it in. I...for the little bit that I was there, I don't remember them discussing it, but I did miss a chunk of it in between, so.

Larry Wolf, MS – Principal – Strategic Health Network

So I'll make a plug that the Healthix thing is a great example of...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes.

Larry Wolf, MS – Principal – Strategic Health Network

...delivering net value to the member organizations; and I think that that's a kind of alignment. It's a listen to your customers, create the thing they need, get everybody's data, pull it together, integrate it; I mean sort of the driver for doing the work. So, I would argue that they are addressing that need for alignment with the community.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup, absolutely. No argument that that's what they're doing. Over here I'm trying to be pure to, what did they say? But it's...

Larry Wolf, MS – Principal – Strategic Health Network

Okay.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...but no argument that that's important and that they've actually solved it. Since we did ask everybody to come and tell us about your three or four biggest challenges and what you're doing to address them or how you think you might address them, I want to keep pure to what it is that they raised as the biggest issues, because that...it might mean that from their perspective they've it already, so it was not important to raise it at the discussion. And, you know, we'll take the judgement call as to whether it really is, you know solved nationally or not, which, you know intuition says it's not and we'll go through it.

All right, okay, this is...let's come back to other Larry's points. So Larry, you mentioned, I think you mentioned two points in one actually. You mentioned the...first of all it is not frictionless to be able to query and retrieve the data or push the data out, and in fact, I recall as well the gentleman from Aledade spending a bunch of time giving us a number of actually valuable metrics, which I captured here, around the cost of extracting the data from the EHRs for even simple things like C-CDAs, to the extent you can call the C-CDA a simple thing.

And then you raised a second point about, you know even if you do overcome that friction, then the...that doesn't mean you're getting the data that you actually need to because it may not be in there. I...so I think...so I agree that I heard both of those points. I think the beef that you might be raising is that it's not actually largely solved, maybe it's incorrect to characterize it as largely solved in that misleading column J, and I'm happy to change that, if that's the main disagreement there.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

That's exactly correct. Thank you.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Sure, absolutely. Okay. I have no idea why I've put this as largely solved, I'm pretty sure that's not the case, but...like this column J right now is a little bit of, I don't know what the right term is that you can use on the phone, but it's...on a public call, but it's not the most accurate column right now. All right, any other points? Anybody else want to bring any notes, and let's actually...let's start pivoting to a slightly different discussion.

So we have...sorry, I just asked a question, I'm not giving anybody a chance to answer, sorry about that. So we've gone through, we've come up with this...set of needs, it's actually quite the list of needs that we have here, and I'm sure it's still not fully comprehensive, but it is, you know 45ish needs, which seems like a good enough list to say that you did some work. We've identified that a lot of them are very necessary for the use cases, and we have now some input. If you think about what we asked our panelists to come and do, we came...we asked them to specifically come and tell us what are their challenges, their top challenges and what solutions, if any they're exploring to address those challenges.

So we have sort of the metadata point that they came and told us about their top three challenges and based on where they came from, they may or may not spend times on things which other people think are challenges. So to Larry, your point around Healthix, they didn't talk about trust framework, but that's because they've done something big by solving it and they're looking forward to their actual challenges, which is no longer the trust framework presumably.

From here we need to look at these panelists as data points, our internal discussion of use cases as data points and bring in a little bit of judgement in what was trying to be encapsulated in column J, but not so successfully in terms of if we think the problem is solved or not, and outline the top three to five that we think...and what I suggest we do is we come up with the top five-ish problems which we think are unsolved in the interoperability experience, or lead to the interoperability experience today and separate that from what is it, if anything, we'd want to tell ONC to do about it.

Because we may identify that there are some problems which are acute, we do need to fix them, they need to be solved, we may or may not want ONC to actually, you know do something about them, or the task force to do something about them because other forces might take care of those problems from the market anyway. Or maybe we just want to monitor it or something like that. So let's start with the top three to five problems, and I'm at a little bit of a loss here as to how to use this data really to identify the top three or five. I think we can start with discussion and maybe a framework will emerge for being able to pick them.

The first thing that strikes me right away is exam...obviously use the current screen as example, ability to identify patients nationwide; certainly an important into interoperability, there's no arguing that. Did not seem to be the challenge that is in front of most people today, they didn't, you know not many people actually brought it up as a critical issue today. So maybe that does not make our top five list. That's the way I'm thinking about is, anybody want to take a different approach or just build on it and start working through what could be a list of the top three to five problems we'd want to articulate?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

So this is Janet; one of the things I was thinking about, and it's sort of a counter-test; I'm not sure how we would fit this into the framework, but one way to think about the top three to five problems are the ones that would get the most gain for the smallest amount of effort or...so in other words, which are the low-hanging fruit that could actually be addressed and solved to your point, to remove some of those...that friction to interoperability. That might not even be the most important thing, but it might be some of the blockers that allows the...that when removed, allows people to actually work on the most important thing. I'm curious to what folks think of that.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

This is John; I think that always make sense to do that that approach. But I'm going to go back to something I commented on or I asked earlier which was the lens of the functionality that's most needed to create the most cost savings or quality improvements, back to the value piece on this.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So John, you're sugge...are you suggesting that, umm, it is the...actually, are you suggesting a specific one of the top three to five problems as opposed to a framework which is actually...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

No, I'm not...no, I wasn't hopping on the problem yet, but I was just following on Janet's think about the low-hanging fruit and the pieces that are going to get the biggest bang for the effort. But I'm also saying that at the end of the day, we...I think that we should be thinking about the technology or the problems here that are going to get at the most important use cases around value.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Oka...John, how do you think about value? How would you...how would we articulate value here or narrow down what is more valuable than something else?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well, so I, I mean I'm heavily influenced by the comprehensive Primary Care Initiative that we're in the fourth year of and the different milestones that all address quality and all address utilization. So, I mean, I have to be thinking about that for every single practice we deal with and every single provider and every single patient. So, I'm always thinking about unplanned 30-day readmissions, umm high utilization of the hospital via ED and admission and those types of things that are...and also the, you know the 5% of the Medicare patients that are costing the most money and the 15% that are costing the commercials the most money. So that, I mean that's always influencing my thinking when I start looking at use cases.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, got it. All right, okay. So here's my take on it, in response to Janet and John's comments. I think low-hanging fruit/most value for the effort is a good framework for us to start with. Maybe we should sanity check at the end to see that we did not punt on something that, remember what's interesting about being a...about working in the context of the HIT Standards Committee and the HIT Policy Committee is that we do have access to some tremendous people and resources and thinking. And maybe we'll come back and say, well actually there may be one or two problems that are not low-hanging fruit but we would be...we would have missed a great opportunity in having some folks starting to think about how to solve them at a more global scale. So...

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

And I had...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...we may actually want to do exactly the reverse as well, even if that's not where we start.

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

I have a, can I make a comment?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Please, of course.

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

This is Jorge. I think it would be good to maybe have a discussion collectively with the group regarding sort of the, you know if we date ourselves back...on the problems that have yet to be solved, one of the biggest problems that I have observed both at CMS and VA is the chiasm between on...it's pretend we're in a boxing ring; on one side you have interoperability, and the other side you have usability. And these are two often times polar technical drivers that really, really create I would say most of the problems in the health IT space.

So when people ask me, what are the two areas that you need to focus on, usability and interoperability seem to always be discussed at almost every meeting that we attend. But there's no technical solution to try to solve or bridge the chiasm between these two almost polar opposites. So as far as, you know there are to dos and the problems and maybe the value that we can bring to ONC, I think we have got to stop talking about these two entities as two fighting entities among each other. How do we reconcile these two tensions that we have between interoperability, HIEs, technical solutions and the frontline usability that clinicians have to be is ultimately the people that are going to be affected by these systems are going to be the people that have to do the work, meaning either the clinicians or the data brokers or whomever that has to actually do something with the data.

And so to me...that would be my...one of the observations after hearing many, many years of testimony in the...forums that we've got to do a better job at crossing the chiasm between interoperability and usability.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That's an interesting insight, for sure, Jorge.

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

I mean, we're dealing with that at the VA, as I'm sure everybody knows, day in and day out where people now are thinking about, you know removing multi-million dollar systems because we've wasted so much money trying to chase the interoperability black hole.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yeah, and in some ways I think that's what we are...what we have achieved at least in our discussions and with this list is that in order to improve the usability, there is some necessary technical interoperability that has to work, and so what are those components and how much of that is solved and how much of that is not solved. But I think you are right in the sense that that in itself is not enough, what we have to...and as I think we have tried to do over here as well, at least we are moving in that direction I think, most all the members kind of agree on that is that there is a...the experience part of that, which is, you know usability in some respects, is as important, if not more...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well and yeah, this is John and I'll...to add then after those two, interoperability, usability then the whole workflow, role-based workflow redesign and training.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yeah, so I think the point is that some of these terms mean different things to different people in some respects, but if you combine all of these things together like, and to some extent I think we were doing this, in number seven which is, there is the workflow design is the visualization and how the data are presented. It's also about developing insights in some automated fashion as much as possible, to reduce the cognitive burden on the end user, to make those decisions. And then making sure that there is, reconciliation of data that is coming from different sources because we know that for two...for improved experience or usability or even workflow, the data would be generated from different sources and will have to be brought together. And so that piece of reconciliation...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah, it is the...John again. Just to clarify, when I say workflow I'm not talking about usability, user interface, I'm talking about actually staff retraining, I mean I...when I heard the comments earlier about clinicians having to do so much data entry, I can't speak for the inpatient side, but on the ambulatory side, I mean I cringe at that because role-based workflow has not been handled properly if the clinician is having to do a lot of work when they're seeing the patient. So that's what I meant by workflow redesign.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yeah, yeah. No, that's a good point.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup, that is right. My...so this is Jitin; I'll speak not as Co-Chair, but as just as a member of the task force as well. When I think about some of these issues in the experience that require workflow redesign, it occurs to me that the more the experience has been built to be seamless anyway, the less you need to worry about training of staff and so on; that's something we certainly struggle with on a day in and day out basis on a...in terms of running the network that we run in CommonWell.

But to the extent that what you're doing it just feeds straight into the clinical care delivery and requires less thinking about entering, capturing and exchanging data, then you've, you know you're probably closer to the solution than where it requires a lot of training and that's not easy. But that...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

I agree, yeah, I agree with that.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...that's where I put my eggs. All right, so here's where we...we are clearly just about out of time; we also have to open for public comment. My suggestion is that we do...we actually assign some homework to everybody, not a ton of work, but definitely a little bit of thinking and some messages back to us. And Anjum and Michelle let me know if you think...if you guys think this is okay.

My suggestion is that everybody on the task force, everybody who's here, send us, let's say us is equal to the ONC team plus Anjum and myself or any one of us, whoever you have handy; send us your top three needs that you think need to be focused on at the national level, all right? And don't worry about the recommendation as yet as to how we tackle it, but think about the top three needs and color it if you can with the use case under which you are thinking about that need.

So for example, Jorge, I'm going to totally put words in your mouth, but if usability and the visualization that is particularly critical, especially in the transitions of care use case or the shared care plan use case as opposed to the quality improvement use case, which is more of a population health use case. If you can share a little bit of context around it, but give me...send me only your top three. And what we'll do is we'll pull these together and more or less make it like a vote and see if that approach works.

Again, this hardly much science over here, but I think if we get everybody's top threes, we'll be able to get a pretty good picture very quickly as to what people think are the most important problems to solve. If we can do that by the end of the week, since it's really just hopefully three bullet point e-mail, a three bullet point e-mail that we're asking for, then that'll give us enough time to work in advance of the next meeting.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Hey Jitin.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

One thing especially for people who manage their days by e-mail and also those of us...or those who aren't on the meeting, can you send this out as an e-mail and attach the document so we know what we're choosing among.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Absolutely.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Yes, I was just about to say that, thank you Janet.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Absolutely, thank you Janet. That's a very good point. How can I turn sharing back to you Michelle?

Public Comment:

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Okay, Lonnie, can you please open up to public comment?

Lonnie Moore – Virtual Meetings Specialist – Altarum Institute

Yes. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the telephone and would like to make a public comment, please press *1 at this time.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

It looks like we have no public comment. So as suggested, we'll send the follow-up e-mail with your homework and when it's due and then we'll talk to you all during our next meeting, which isn't until June 1. Thank you all, have a great day.

Jorge Ferrer, MD, MBA, LSA – Biomedical Informatician –Veterans Health Administration

Thank you, thank you everyone.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Thank you all.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you.