



Collaboration of the Health IT Policy and Standards Committees

Interoperability Experience Task Force
Final Transcript
June 14, 2016

Presentation

Operator

All lines are now bridged with the public.

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 Health IT 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

Khurshid, I always butcher your name, I'm sorry. And the same with Jitin...you must hate me. Anjum and Jitin, you're here as well.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes we are.

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

John Blair? Cris Ross? George Cole?

George Cole, MS – Principal Scientist, Community Solutions – Allscripts

George is here, yes.

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

Hi, George. Jane Perlmutter? Janet Campbell? 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 Garber? Phil Posner?

Philip Posner, PhD – Patient Reviewer – PCORI

I'm here, good morning.

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

Hi, Phil. Shaun Grannis? Ty Faulkner?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

I'm here.

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

Hi, Ty.

Ty Faulkner, MBA Adjunct Professor – Lawrence Technical University

Good morning.

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

From ONC, do we have Stacy Perchem?

Anastasia "Stacy" Perchem – Public Health Analyst – Office of the National Coordinator for Health Information Technology

I'm here.

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

Hi, Stacy. Okay, so we have a small but mighty group this morning...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Hey Michelle; sorry, this is Janet, I just joined.

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

...but we'll make do. Hi Janet, thank you.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Sorry.

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

And with that I'll turn it over to Anjum and Jitin.

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

Thank you, Michelle. Welcome everyone, good morning. Again, thank you very much for joining this call. Next slide, please. So I wanted to make a few points before we get into the meat of our discussion. We will talk about mainly our recommendations that we are supposed to present to the joint committees and we would like your input on that. Next slide, please.

So...and before I go, I think I must thank the task force members and all of you for really your thoughtful insights into this process. We understand that all of you are very, very busy, but I think we received very, very good discussions, or we had really good discussions on these topics and are hopeful that the work that all of you have been able to put into this will help move the interoperability at a scheduled level forward...we are really grateful, both Jitin and I are grateful for your input.

And what we have tried to do, I think as Co-Chairs is basically to capture the overarching themes and recommendations that have come from these virtual meetings and we have tried to do our best, so please as you see the content that we propose to present to the joint committees as our combined work for this task force, please feel free to correct us or just to clarify things that will be presented to the joint committee.

The other thing I wanted to mention was in terms of our task, just to see where we are. From what we understand our first task was really to narrow the scope of this really broad topic, in terms of how we improve the interoperability experience for providers and patients. And to a great extent I think we were...we had really rich discussion in terms of how we can narrow that scope to the most impactful aspects of the interoperability experience, which we have tried to do.

The next piece I think was you were also required to get input from the field. So we can move to the next slide. And through our virtual hearings and through input from, you know very diverse task force membership, I think we were able to get at least some of that input as well. So we complied with that aspect as well.

The third aspect that we saw of our charge was to identify if more detailed work was required on some of these priorities that we have identified. And as you will see in today's discussion that we will propose certain things that we think were part of the discussions that we have had and that's probably the main feedback or input we would like to have from you in terms of do they reflect accurately and appropriately the discussions that we have had that you wanted to contribute to this area.

So as we move forward, on June 23 we'll be presenting these recommendations, most of the slide deck as you see it today, to the joint committees. And usually how it works is that the joint committees will read these, they'll discuss this and hopefully will approve in principle, or they may actually question some recommendations or they may send some questions back to the task force for clarification in the timeframe between our presentation on June 23, which is an initial presentation of our recommendations, to our final presentations towards the end of July, when we formally present these recommendations on behalf of the task force.

So that's the trajectory we are going on. I think we have through actually mainly your efforts and your inputs and a very fine ONC team that has supported us, I think we have made good progress and the slide deck I think is a proof of that. So, as we look through these slides sets, I would urge you to think of

this from a point of view of when this information is presented to the joint committee, people who have not necessarily seen the slides over and over again as some of us have, are these clear? Are these reflective of the discussions that we are having? And then again, are these meaningful in terms of moving the interoperability experience forward nationally, in terms of policy and technology recommendations that we were asked to do?

So again thank you very much for this. Next slide. And I think at this point, Jitin is this where you take over?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

I'm happy to, I'm happy to do so.

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

Okay, great, great.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, terrific. So I want to just add two things to what Anjum's just articulated; one is, at the end of this work, this initial work...task forces, you know mandate, our charter, what we'll have is we would have set some of the ONC agenda if our recommendations are sensible, then we would have set some of the ONC agenda for tackling interoperability issues over the course of the coming year.

And so when I...when you think about what we've done so far, in large part it's not...I don't know if we have broken a whole lot of new ground. I think we're going to be shining some light on where additional focus needs to be placed. So as we think about what we're going to have achieved at the end of this task force, although for a couple of us, particularly those of us who are product managers and engineers, and probably all of us but I can only speak for those things I've done before, it is sort of a different characteristic of the success because what we'll have is really a set of recommendations that says, let's go, we need more people to go figure "X" or "Y" or "Z" out as opposed to we have figured out "X" or "Y" or "Z."

So let's just keep that in mind and let's just make sure that what we do then is that we...it's actually in some sense a bigger mission because you're going to be setting a whole bunch of agenda for and work for future task forces to go down. And we want to make sure we've actually framed something that's worthwhile for them to go pursue. So let's keep that in mind.

The second thing is, we have, you know the next few slides really articulate what it is, what we're going to share with the joint committee next Thursday, so that's on June 23. And they've obviously not come down the full pathway with us that we've come up, you know over the last four or five months or so, so necessarily a few of these earlier slides that we're going to look at right now are very repetitive.

We're not going to spend a ton of time on them right now on today's call, and I'm certainly not going to do the voice over that we'll do at that time. But you can imagine that it'll take at least half an hour or whatever that time amount is, something not insubstantial to go over where we've been so far and how did we get from a very, very broad scope that we started with to something which may actually result in a two or three actionable follow-up items that this task force or other task forces will be asked to pursue.

So as we go over the next few slides, mainly recapping the background that we've gone through, let's not overspend time on it because what I'd really love for this group to do is to make sure that we've hygienically captured everything, there's nothing here that's really misleading. There's nothing here that you think really ignores an important that you or the herd raised or that you yourself raised.

I want...we really do want to make sure that as chairs Anjum and I had the duty to kind of put this back all together, but neither of us are pros and neither of us can claim to have, you know with 100% accuracy caught everything. So please just help us to get it right. And as we get into the last few slides around the recommendations, there let's spend much more time...let's...you know, just critically analyzing what the recommendations are that we want to make. We're all very familiar with some of the repercussions of recommendations made to ONC and to the task forces, so let's ensure that we are doing the right things there and setting those future bodies on the right path for discovery and progress.

All right, with that long preamble in mind, hopefully you guys are still awake largely, this slide is...as you can recall, this is the...when we started out we had a broad, a very broad mandate and we said, well let's come up with a set of use cases, a small set of use cases that largely cover the interop space, and if we analyze them and figure out what are the key components of them, probably we'll be on the right path towards figuring out some of those needs in the industry without boiling the entire ocean of potential different use cases out there. So this is just those same use cases. If anybody...I don't think...if anybody has any questions about it, please just interject otherwise we'll go ahead to the next slide.

As we went through those use cases, if you recall we came up with these seven categories of needs, and each of them had their own sub-needs within them. We didn't capture all of the sub-needs here but we caught most of them so that anybody reading this would understand what some of those examples are. Maybe we should actually call out the words...examples of sub-needs here, just the word examples, just to indicated, because I think I went back and counted them, we had 36 sub-needs and 7 top level needs, so 43 needs altogether, which is quite a lot of needs.

And we just placed them over here as an opportunity for folks to understand what it is we are talking about by these buckets. But these are the seven buckets we came across and at the end of our deliberations, if you recall, at least the framework that we started going down in terms of the, how important was it to the interoperability experience relative to other needs, we really didn't get enough sense of distinction among the seven buckets; so all the seven buckets really stayed at the same level. Before we go on to the next slide, anybody have any questions here? Is there anything that we've misrepresented here or mischaracterized or just missed out altogether? No, okay.

All right, let's keep going; let's get to the next slide. Great, so then after...so at the end of that, our own deliberations, what we came up with was, well we said let's get more panelists...let's get more industry stakeholders involved across the healthcare industry. We came up with a broad set of community stakeholders. As I look at the stakeholders on the left-hand side, there were tw...in my mind there were two really positive aspects of the stakeholders we selected; one is we found some stakeholders, you know companies like Cerner or athenahealth for example or Surescripts, some of the information exchanges who have participated before, they're able to share their experiences and bring sort of the veteran feel to the table.

But we also, on the counterpoint, had some brand new companies come and participate. And that was something that was...that's going to be good for...which was good for our task force and is good for ONC

really and the committees for the longer term, because we do need a broader set of stakeholders having input into healthcare technology. You know folks like Get Real Health and PatientPing; I don't think they've ever participated in these panels before, so it was a great opportunity to get some new folks involved.

The themes, on the right-hand side; these are the themes which we think came up the most. As we looked over the transcripts, as we went back to our notes on the discussions, I think these are th...I'm sorry, we think these are the themes that came up the most in column A, or rather bullet A important or an indication that they're broadly unsolved issues versus column B, or sorry, bullet B, you know less important issues or infrequently cited issues; and both of them are important to call out because it may indicate that there is...that somethings are more important than others.

I'd like us to spend a moment on that...on this themes bucket. Is there anybody who as you read through the themes and the themes buckets something that's either missing or we should add or mischaracterized?

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

Can you hear me?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes we can hear you, is that Jorge?

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

Yeah, this is Jorge. I think on the sub-bullet A, data reconciliation; I'm not sure it's data reconciliation but information reconciliation. Patients are not pieces of data so when you're clinically reconciling, what you're reconciling is actually information. Those data elements or data pieces may or may not be reconciled when you're actually having to task. But I would say that I would also have added it's not data, it's actually information and you know clinical information if you really want to be precise, but it's not the data you reconcile, it's the information that's clinically viewable.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Jorge, let me push that a little bit, just so I'm a little bit more clear.

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

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

You think its informa...sorry; you suggest its information reconciliation as opposed to data reconciliation. Are we talking about the same thing, like in my mind when I read this I was thinking about umm, let's say diagnosis and problems and things like that; are you thinking about the same thing but you're saying that it should be called information rather than data or are you thinking of something else?

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

Yes, correct. I mean the examples you gave that's not data, that's clinical information and so call it what it is and its clinical information.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right. I don't have any push back on that, I'm comfortable with that. Anybody else? Sorry, Jorge, any other items over here on the right-hand side that we should think about? Actually, let me just do a double check, since I joined the meeting just a minute later than I planned to. Stacy, are you going to capture some of these notes as we go through these early slides particularly?

Anastasia “Stacy” Perchem – Public Health Analyst – Office of the National Coordinator for Health Information Technology

I sure am.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Terrific, thank you Stacy.

Anastasia “Stacy” Perchem – Public Health Analyst – Office of the National Coordinator for Health Information Technology

You're welcome.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

One of the things that I...

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

Jitin?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes, go for it Larry or John.

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

This is John Blair. Looking at the themes mentioned under “B,” less important, functional limitations of existing vendor solutions; how did we come up with that being less important?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

It was really infrequently cited more than less important. It did not come up a whole lot in the panels, at least from what we could tell back John. Did you hear it a lot more often? Is it in the wrong place?

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

Well, I don't know, to me I don't think it's less, I mean from our experience. I mean when I look at the early days of ePrescribing a big piece of that curve being flat for the first several years was functionality of vendor products and I, I mean certainly for Direct I think that's very much the case. I know content and directories is an issue, but functionality is a major problem, particularly on receiving messages.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Maybe we could just make that like less of a value judgment and just, you know frequently cited and infrequently cited.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, maybe that's...that sounds...

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

I agree.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

I think that's a good idea, maybe that's what we'll do. Okay, Anjum, does that work for you as well, I know we...

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

Yeah, I think that was a good point from John because what we can state here is how frequently it was cited in the panels and we didn't necessarily have the discussion of which is more important than the other. So that's probably something that we can assume from this, but not necessarily, as John was pointing out. So maybe Stacy's proposal of making these categories more as these were frequently cited and these were infrequently cited and which was the basis on the "A" and "B" lists.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay.

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

But then that begs the question, who were we speaking to? Because if we were talking to clinician end users, it would be different, but, you know I don't want to belabor it but, it depends on who we're asking questions of.

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

Yes.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, that's absolutely right. So from this audience, that is what we heard and that's absolutely why we captured this information only on this page; it was still up to us have a subsequent discussion as to where things go. And that we'll get into on the next page. If...from my look...just thinking back to where we started and where we ended up at this point of the process, when we had the hearings, it was, I did not hear provider directories or even patient record location mentioned. I don't remember if they were mentioned at all on the panels. Were they mentioned at all, because I wonder if it's worth calling out that they were infrequently cited, although it may have been just never cited? Does anybody else recall if they were cited as well?

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

I don't think they were cited at all.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Is that worth calling out? I remember being surprised at the time, and I'm sorry we forgot to put it on this slide, but is that worth calling out that those few things were not called out at all by this group? And again, to John's point, it may just be who the group is, but the fact that they didn't bring it up?

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

Yeah that's an interesting question. As I think about...because I really think about end users all the time and if you were to ask clinicians or their ancillary staff, they would never call it provider directory, they would just call it the ability to find a provider or know a provider as they're using the software. They never think of it about as directory; it's the technical people and others that are calling it provider directory.

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

Sure.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup. There's another piece to it as well, right? This leads...the basis of this...of our hearing was what are your top three problems, and I would have expected a Cerner or an athenahealth, maybe a Surescripts, maybe PatientPing, or actually one of the healthcare stakeholders at the top to have said, you know they each gave us their top three and for none of them did provider directory or even patient location come as a top issue. Maybe these stakeholders...

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

I think it's worth mentioning.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...found that it was solved well enough or it just wasn't as im...you know, for them it wasn't as big a deal as the other priorities that they did bring up here on the right-hand side.

George Cole, MS – Principal Scientist, Community Solutions – Allscripts

Well it's George, so I'm going back through notes and I wonder if some of this was implicit in some of the other statements. So for example from Sutter Health we get, "one of the things that's missing is bidirectional messaging for collaborative work." So, if you can't find providers with whom to message back, you know what I'm saying. So maybe there's some implicit assumptions about connectivity and the ability to reach others that are hidden in these other messages that we got.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right.

George Cole, MS – Principal Scientist, Community Solutions – Allscripts

But I agree they didn't call it out specifically.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Great, so here's what I suggest. I suggest let's call out a couple of those things which they really didn't mention at all over here. We do have a page where we speak about what are some things to think about, I think Larry Wolf called it out as, there are some caveats; and I think it was Janet and Larry at the last meeting who suggested well, there are...if you do the...I'm sorry, Larry Garber and Janet who suggested that there's a root cause analysis that this doesn't necessarily get to, which we call out

another page, so I think maybe we call that out there as well, George, that there may be some implicit assumptions here around what you need to make this happen.

I know Larry Wolf and I had an offline discussion specifically about that as well and came to the same conclusion that we came here and on the next slide. Let's just go to the next slide for a moment. Oh sorry, not this slide. We brought in some of the illustrative feedback, we won't go through it here, but if anybody has any comments, please let us know if there are comments or if there's another quote you'd like us to include, just let us know. Let's go to the slide after this.

Oh man, I've completely forgotten my order of slides. Anyway, there's a subsequent slide where we call out what it is that we ended up...we realized what the focus was and actually maybe this slide doesn't do a bad job of it. As we went through this discussion, what was interesting is that some of the architectural components like provider directories, like patient location and other pieces, did not come to the forefront of the experience discussion; they were, you know George, to your point, they were implicit in the discussion.

But most of the discussion, even from the panelists, focused on something which we just kind of...focused on these pieces the delight in using...in being able to interoperate and the friction in trying to interoperate. And, you know you can almost imply, and I suggested this two meetings ago that it seemed like there was some sort of proportionality here between the interop experience and the user delight versus the perceived friction and it seemed like everybody largely agreed. This is the first time I've actually put it on paper in front of you, does everybody think this is a fair...one of the fair conclusions to draw from the work we've done so far from...specifically from the point of view interoperability experience?

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

I think it's beautifully depicted. You know, some people can quibble that user delight is actually the use or experience, but if optimization of a clinical application is the delightfulness by which technicians feel that he's not labor with a tool, then you know, I mean it's pretty accurate, I like that.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, awesome. Terrific. All right, are there any other comments? Otherwise we'll go on to the next slide.

George Cole, MS – Principal Scientist, Community Solutions – Allscripts

It's George, I'm really glad you used the word perceived, I like...I really, I think that's very important here.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah. Actually I went back and forth on that one; Anjum and I were discussing, is it actual friction or is it perceived friction and we kind of thought, well now sometimes it is actual friction, a large part of it is perceived friction and it always comes down to the eye of the beholder.

George Cole, MS – Principal Scientist, Community Solutions – Allscripts

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So we stuck with perceived. I'm glad you like that, thanks for honing in on that one, George. We did struggle with whether to keep that word in or not. All right, let's go to the next slide. There we go. All right, so based on what we learned from the hearings and accounting for the fact that yes, there was certain set of people who were at the hearings, and then there's a certain set of us, of course, on the task force itself.

As you guys...as you all know, we did a offline vote just to get a sense if...what the top really, the themes were and three really just bubbled up to the top, you know two that we had articulated earlier when we had gone through the use cases and a new one that really came up in the...came up by virtue of the virtual hearings, the ability to meaningfully utilize the data. But certainly did resonate largely with members of this task force, and please correct me if I'm wrong, but I certainly felt like yeah, that was something that was missing.

And we'll go into what that means in a subsequent slide, but there was certainly something much more closely akin to the user experience that you'd think about when you think about you know using an...any online platform like an Amazon or a Google or what have you, that was missing in our initial set of big buckets. One way of thinking about this is that third bullet on this page, you know focusing on these aspects, the items in orange is really focusing on those things which will drive interoperability demand and create the kind of pull through that will in turn drive better infrastructure on the supply side, so the patient location, the provider directories and so on.

And the reverse is also true, too. If you don't have some infrastructure in place, you can't get to the place where you're honing in on what makes a better interop experience. So it's a little bit of push and pull there and I think what we realized that when we are focused on the interoperability experience, it's really about that pull that makes a big difference and it's particularly distinguishing to the work that we were doing. All right, I'll stop there on this slide; any comments? Comments, questions, suggestions?

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

On let's see, the first column, last orange...ability to meaningfully utilize the data. Once aga...is that utilize the information? Once again, you know clinicians don't look at data; they look at information that's a compilation of...things called data.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right, ability to meaningfully utilize information. And maybe, oh, maybe over here it is actually worthwhile calling out clinical information or maybe not, maybe we can stick with information because it could be an interop experience that encompasses payments, too. I don't have any issue changing that; does anybody have any issue or concern of the words data versus information? I know sometimes a single word can make a big difference to people, so I just want to be sure.

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

No I think that's...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I think that...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

I'm sorry; we have a couple of people. I think I heard was it Anjum going first?

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

I just said that was a valid point.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, terrific. And I think that Janet was adding something as well?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I was going to say, I'm fine with that, but I was going to add that right now it's not entirely clear that your yellows are selected and your blues are unselected; you might want to gray out your blues a little more, just...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay that's helpful. Thank you Janet, that's helpful. I'm laughing because that's like perfect feedback from Janet. If anybody was going to point it out, it was going to be Janet who points it out.

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

That's acquired usability right there.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That's right, that's right. That's...ability on this slide. That's great.

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

She's a usability expert, no doubt.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That she is that she is; thank you, Janet we'll definitely do...I agree, I totally agree. Okay, it looks like we're okay with that word. Let's go to...so we're going to change data to information, just to be clear. All right, so the next three slides just go into these three buckets and expound on them a little bit more. Let's spend a few minutes on them, just to make sure that we have captured the aspects that we understood from them.

Again its ability to encode the data so that it's syntactically and semantically interoperable, ability to exchange the data, the ability to meaningfully utilize the data. I personally sometimes get a little confused between ability to meaningfully utilize...sorry, the information versus ability to semantically and syntactically encode the data properly. So let's just keep an eye out and make sure that we're all clear on those two buckets, and then after these slides, we will get into a slide on caveats and a slide on recommenda...and a few slides on recommendations, which is where I hope we spend the bulk of our time today.

So this is ability to meaningfully utilize the data and what we wanted to capture here, and this is our rough draft, sorry we didn't plaster this page with the word draft. But our...this rough draft, the intention was to just make it a little bit more clear for the joint committees as to what it is that we...we're thinking about meaningfully utilize the information. Let's make sure we change that word

over here, too. Let's just take a look and please let me know if you think something doesn't quite sit right or if there are any changes we should make.

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

Are you concerned with persisting the data as opposed to the information in the top heading or do you care?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Are you speaking about a specific bullet, Jorge?

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

The ability to meaningfully utilize the data.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

You mean...so you mean at the top level are we concerned about persistence of the data?

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

The ability to meaningfully utilize "the information."

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, to utilize the information; yeah, we should...we'll change the word here for sure to be information. Sorry, was there a separate point about persistence that you specifically want to talk about or just reminded to change the word here from data to information? Jorge or anybody else? Any other...

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Yeah, this is Ty guys, bullet two on curation and cognitive burden; just want to make a point with respect to different cultural health norms on health data and the whole concept of fifth grade level, eighth grade level and the cognitive burden. Somehow reference in there that we take a special note to underserved populations and the adaptation of this data.

And then I don't see in here anything related to the actual purchase price or cost burden; maybe that's in here but, how do we reduce the...that barrier for the consumer, because at some point that consumer is going to be faced with, do I, you know, we're talking like a Medicare now, right? The elderly, do I put money towards or any patient type really but, will this actually come out of my pocket and how do we put our arms around the cost burden?

Because we're doing such a great job of making all this interoperable, but we really haven't addressed one of the key issues which is, you know at the end of the day if the patient has to choose between lunch and the cost burden of getting to my data, they're going to pick lunch. So I don't know how we wrap...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

...our arms around that, and maybe it's not our scope, but we can do everything we can to systematically and semantically make everything available, but then if a vendor slaps a high cost on this we're stuck.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, those are both really good points; I think I see them as two different points. The first point is in the second sub-bullet here, greater intelligence and curation process to reduce cognitive burden; maybe we should have some sub-bullets underneath it that remind us that there is...that this applies to providers and this also applies to patients.

And patients can come in...to your...I'm not sure if I can say it as well as you just did. But patients come in, you know patients will have different needs and cognitive burden means, you know will mean something different based on the patient population. So there...but there's a distinction here because certainly when I read this thing I just think the physician, the provider but it's probably true...it's true for both. I'm...

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Right, right, so health literacy you know is an issue in our country right now, it's a huge issue. We tend to throw out health data from the perspective of the provider, but as we transition from three to four in terms of the processing and outcomes to actual patient engagement, you know we're...there's a great cliff I call it there that says, what are we throwing over the fence that they really get, you know that's meaningful, blah, blah, blah. So, yes.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Absolutely. And okay, so I think we're on the same page there; we'll take a stab at the...

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

I have a question.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...at this bullet and we'll probably get some response. I don't want to ma...I want to make sure we don't lose your second point, but let's come to that in a second, I think Jorge had a question about this.

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

I...on reduced burden of physician/staff by increasing automation of data entry and data import...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup.

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

...the language there should be reduce the clinical burden of data entry; automation may or may not do that. For example, if I am dictating a note and on the macros I am preempted with a voice enablement that I have to re-edit because it got all of the surgical nomenclature that I'm using wrong, then you've created work for me instead of...you thought you were helping me, it's automated, but now you're giving me more time on the application which that's not what I want, I just want to get the thing done and get on with my clinical day. So I think, I'm not sure that you have technically correct there; it's

reduce the data entry burden on the physicians and staff, it may or may not include automation, but to explicitly put automation like that is absolutely incorrect.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. All right, so maybe we can flip it around. So what you're saying is reduce the...the data entry burden and I think there is something about the data import burden that is particularly relevant to interoperability, because the process...

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

Yeah but the clinician...the clinician who's providing clinical care...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah.

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

...you know what you're asking them to do is labor meaning put stuff into a system that's called data entry. The inputting of the data, why should that be the clinician's role or responsibility? I mean it is an interoperability issue that you know ideally you would want to serve that information interoperable so that he...viewing it and seeing so that he can do what he needs to do, clinical reasoning and then does his data entry. But it seems that we've got two very different things here on this bullet.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So I'm...I might need some more help there, Jorge. So I totally agree with moving automation to a sub-bullet which could be an e.g. right?

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

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Auto...you can see automation could be helpful, but there could be other things that are helpful.

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

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

But I don't s...can we walk through what the difference is between entry and import here, because we just may be using words...

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

Sure, sure.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So let's say a...you're a physician and a C-CDA comes to your door, let's say it came through Direct, somebody pushed you a C-CDA.

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

Mm-hmm, mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So what...in that proc...in the process of getting that C-CDA from where it's on your, you know in your inbox let's say to the point in time where you're usefully...you're able to actually utilize it, what do you see there as import versus entry?

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

Okay, so that's a perfect example. If you are receiving a patient for a surgical consult and a C-CDA is dumped in front of my eyeballs to comb through and review, that is a very labor-intensive work for the clinician on the navigation for clinical contextual nuances that I need to make clinical decisions. So now I've got to comb through all this...but that's...I'm not entering data, I am navigating and I'm hunting for the white rhino. So I'm looking for information and I'm navigating, but all of those two things are eating up my clinical time. That is that data import problem, not a data entry, because I haven't entered anything; I'm right now in the viewing mode.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right. Okay, all right, I got you.

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

That's a good example.

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

Yeah, that's probably the wors...the best example you can give me because that's the one that really cripples people and the one...because you're eating their time by thinking you're helping them by dumping these C-CDAs, and then they're spending all this time hunting for something has very, very low yield.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So they don't do it, so the chances are...

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

Well they do it once or twice and then they're like, why am I wasting my time with that thing you call C-CDA?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right, right, yup. Okay, that makes sense.

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

And you know, the C-CDA is only an exemplar, this is, you know I don't want to beat up C-CDA it's just an example of stuff that you're putting in front of a clinician; it's the information you're putting, clinically relevant for the point of service that they had to deliver.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup, all right; that is great. So then let me ask you this, I mean take that one...let me take the, maybe it's the example, take it one step further. So I...this definitely sheds light on the import problem, what that means. And then what about entry; is entry really a discussion point for an interoperability discussion or is that really a point for an EHR discussion?

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

That's a great question, I mean clinically if you want to stay pure that, you know at the application level, because interoperability we clinically, you know clinicians want it there, they want to see it, but they don't, you know it's like sausage-making, they don't want to view the sausage being made and right now we're seeing it being made.

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

Well this is John; I would say you do need to include that for interoperability. Again I'll go back to the ePrescribing example I used before. You didn't see transaction volumes go up until that was fixed.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

It's because there's a lot of entry going on of e-data that was sent...that was otherwise...which otherwise could have just been imported but was being entered; am I getting that right...

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

Well I'm just looking at the whole bucket of usability...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right.

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

...when Jorge said it's the application. So...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Oh interesting.

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

...and I mean there's a lot of nuanced components to this, but you know I mean we could talk about things around C-CDA a lot and we can talk about...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Sure.

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

...user interface functionality, patient matching, etcetera but the point is, for ePrescribing there's three or four components to it, but all of that had to be fixed and worked out before you saw usage and so the application does drive the interoperability.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That is a very good point.

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

Yeah...absolutely. Yeah, absolutely, I agree 100%, I mean it's...because that's what that user experience is, it's the application.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

What do you know, sometimes...

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

Did you say...suggesting...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...sometimes you can't just stick to Occam's razor. Sorry, go for it Anjum.

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

I was just saying that it seems like these two are maybe different bullets because they may have different solutions as well, so...and I they seem to be important in themselves.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

I agree and I think that's where Jorge started as well, is that right Jorge that they really should be different bullets.

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

Yes.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right that's great; all right that's very helpful. So also we'll make sure we don't lose the automation point, but it becomes an example somewhere and we break out separately data import and the issue around navigation, maybe we can call that out parenthetically as an example. And the issue around data entry as part of the application experience, which drives down...that drives down the overall experience of interoperability, among other things. I think both important and different points.

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

Jitin, I had another question on this...the next bullet which is around logical integration.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay.

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

And I think that question mark has come from me which is about incorporating the data into the EHR, and I just wanted to at least have any other views from the task force in these two sub-bullets it seemed to me pretty broad there and I just wanted to see what others think about these two sub-bullets under logical integration.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, and that actually just, as you folks are thinking about that, part of the context is, as Anjum and I were creating these...helping to create these slides, what we did not want to do was lose information or lose important discussion that folks had had previously. So some things we captured, we ourselves have questions about, but we wanted to capture it so that again everybody on the task force felt that we hadn't missed anything they had said, even if we all decide subsequently that they are either need more specificity or they're actually just not valuable. So, totally open to feedback as to what we should do

with this one. Any ideas? No? Anjum, what would you recommend we do with this one if you, you know given a choice and we can see what everybody feels.

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

Yeah my own thought was that the sub-bullets may...I don't know if they just add too much description to the main point that we wanted to talk about in terms of integration into relevant workflows. And I think that's an important point in itself, but my sense was the two sub-bullets, I was not seeing how they are like further explaining this without causing like more confusion in terms or what all comes under this.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Do...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I think the point that's expressed in this first sub-bullet is important because it highlights the fact that there are a lot of different needs for data within a flow and not all of them are the ones you might think of. So regulatory is a great example there, right, where you can...if you can use external data to satisfy quality measures, then that is a good thing; but people might not think about it that way.

The second one actually to me just sort of seems like how, the how of how you would do that, but it doesn't add much because it's both too vague and straightforward at the same time, if that makes sense.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, I agree. I agree with both of those comments. So Janet, are we suggesting then that we take the...that first sub-bullet and promote it one level to a ac...to a bullet by itself and then probably eliminate the second sub-bullet?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

That's kind of what I was thinking or at least incorporate the sentiment of the first sub-bullet into a higher bullet.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. All right. Anybody...Anjum what do you think? Anybody else also, if you have any ideas, otherwise right now the...right now I think it would sit by itself, but if there's a better bullet that it should fit into, I'm totally open to that as well.

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

Yeah, I like Janet's suggestion.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. All right, let's do that then. That takes care of an issue we had on this slide. All right, so I'm just doing a quick time check; it's 11:20, I believe we go to the top of the hour, is that right, 12 p.m. Michelle?

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

Yes, that's right. Sorry.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, so let's see if we can spend, let's see if we can spend 15 minutes on the rest of the current discussion and we can...this is...the nice thing about this slide and the next two slides is we can continue iterating on it offline. The recommendations I really think we all need to get to be live and have a synchronized discussion, at least to begin with, so that we can be in the right position for next week.

There is an important point that was made earlier in this discussion right now that I don't want to lose. Can we go back one slide for a second? I don't remember who exactly said it but somebody talked about the cost transparency.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Yeah that was Ty Faulkner that was me. Go ahead.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Perfect, perfect Ty. All right, so the question I had for you was, actually it's not for you it's for all of us. Actually Anjum and I were struggling with this as well because we have a note here on our...at least I have a note here on my notebook that we were trying to figure out where did the cost transparency go? We did used to have it, I think, but I don't remember in what bucket it really fell. I don't think it was into meaningfully utilize information, maybe it was, but I'm not too sure. Does anybody have an idea where it g...maybe that is where it belongs relative to these other buckets; that's the one it makes the most sense to fit into. And again, that's a cost transparency to patients; where would it fit in this set of eight buckets?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

The only other bullet I thought of was the ability...we changed it, but the ability to exchange information, perhaps. What do you think?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, it could fit there.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Either bullet works; meaningfully utilize denotes that you've already gotten through the barrier of finances and now it's, what did I pay for? Did I get a lemon, like a Yugo or did I get a Cadillac or something? Versus exchange is like a toll booth and once you go through, you've paid your toll, I would think.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, well I also...sometimes I think of it as sort of upstream/downstream. Upstream is can the data...were you able to actually exchange the data and downstream is were you able to use the data? And I think where cost transparency's concerned, we're still at the upstream, we still haven't figured out how to share that at the right time, right place, far less the next step of how do you utilize it. But I don't...what do you think, is that right or...

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

It sounds good; I mean either way, yeah.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right either way it can work; all right, so maybe under ability to exchange data that is a point to be captured. Let me ask you this one other question while we're on that topic, did it come up much in our hearings? It came up in our wo...in this task force's discussion so it will be included. But does anybody recall if it also came up in the hearings? I feel like our first two patient advocate organizations, Get Real Health and Galileo had a discussion about it or mentioned it, but I'm not 100% sure.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

I'm certain that McCollister-Slipp, Anna who's a huge advocate on that whole cost barrier, if I recall, I don't have the notes, but I'm pretty sure she tapped into that area for sure.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. All right. Okay, then let's keep going. Let's go to slide 13...12, 13 all right, great. Syntactic and semantic, so we'll come back to bringing that point, Ty we'll bring it back into the next slide, on slide 14, when we get to slide 14.

On slide 13, ability to encode data for syntactic and semantic interoperability. This was interesting that it came up so much we all felt it was really important, but there is some existing work that's already going on over here. What do people think about these bullets? And are we missing an important aspect of the discussion that's not captured here?

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

I have a question, can you hear me?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes.

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

On this particular one, identify a parsimonious set of terminologies, umm terminologies, code sets, nomenclatures are all different things. Interface terminology is yet another example of an application at the point of service, terminology that's oftentimes used by many vendors, the EPICs, the Cerners and the whatnots. And so to blanketly put set of terminologies doesn't really do anybody any service.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay.

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

So you have to actually identify what that means and my recommendation, if you're going to do that because you know with each code set, you really want to be able to identify by name, you aren't talking about nomenclatures, terminologies and code sets and interface terminology. Those are the four things that permit this concept called semantic interoperability to actually be realized.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup, okay I am totally with you. Anybody else have any comments on...high level comments around it before we figure out a way to articulate this on the slide? Any other points besides the terminologies, code sets, ontologies, etcetera that Jorge...for example, is there anything else we want to say about the work on formatting, like the C-CDA? I think we're...it was largely around the code sets and terminologies issue that this slide was focused. So if...unless anybody else has any comments, Jorge can I ask you to help us with this one offline?

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

Sure, sure.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

If you can help us to come up with some language to get this...because I think first of all that first bullet cobbles together two things which should be separate, there's work around the C-CDA and then there's work around the terminologies and terminologies, to your point, is one of four big things that are key parts of clini...of semantic interoperability. So if you can help us with some of the language offline, then we can re-share it again with the committee and see if there's any feedback.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Just one thing that I noticed with this that worries me a little bit, the bit around the coding of the data to improve the specificity of the clinical interpretation; I don't know how best to represent it here but one of the challenges to the usability of an EHR in general is that suddenly when we move to more specific and granular code sets, we are asking providers to document things that weren't documented before and perhaps in some contexts, they're not clinically relevant. So there's always this trade-off then where like you're suddenly doing this box checking that you don't see as meaning anything to you. So I don't know how to call that out here, but it is a bit of a double-edged sword I guess.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, absolutely. Absolutely. The blood pressure example is one that's most often cited, at least at the Standards Committee, but I agree, it is a double-edged sword. All right...also, I will take a stab at articulating that, that's a really good point in terms of the...in terms of trying to figure out how do we account...how do we make that point, even as we talk about specificity? All right, let's go to the next slide, unless there's anybody else who has comments on this slide. All right, let's go to exchange data...double-edged...sorry, let me just make sure I captured those points. All right, there we go.

So ability to exchange data; this is...so this is the discussion that came out I think out of the last meeting. Part of it I was not there for, so I really didn't want to alter some of the notes that I...that Anjum had captured as well. So I will, what do you guys think? And there's...and a point that we have to bring over here now around transparency of cost, about ability to get the cost...patient cost information with the exchange.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

You may want to look at just doing the example after fostering open APIs comma, transparency of cost and just sort of gently throwing a lob up there that it's mentioned and noted and we can go back to it as an enabler.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right. So maybe a couple of examples, all right...fostering open APIs...

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

Just out of curi...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...the transparency cost.

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

...just out of curiosity, why do you think that the API, from a cost...is actually going to be an enabler? What makes you say that?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

So umm, separate points. Open APIs separate and cost. So cost in itself is a...it's more of a barrier that we want to move to become an enabler. Obviously free is great and anything relative to beyond free becomes a barrier, so we're just showing examples of how to enable access. We know it's not going to all be free, but if we can focus on enabling cost transparency, then we enable access because now I know, hey, I've got to fork over some money at some point.

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

Mm-hmm. Because the interfaces are never, ever free.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Ah, you're mentioning a whole different level, that's a great point you brought up tough. Thank you for that, I'm thinking of consumer, but I like that, yeah.

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

I mean, somebody's going to have to write that little check called interface.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

But I think the point is still good though guys just add that in there, yeah.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

You may want to look at it again from the provider standpoint or system standpoint and consumer standpoint.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right. So there's cost trans...now that's interesting. All right, so there's cost transparency to the patient. There is the cost of building an interface...and it...let me, I know that you guys kind of tangentially touched upon it, but let me just push that a little bit more. Is it the transparency of the cost of building an interface? Is that the key point or is it that...?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Yeah, like right now we don't have the cost of interface that we can go to, I mean we have Blue Book for cars, you know we have Black Book for buying an EHR, but we really don't have an interoperability Orange book or whatever color we'll call it.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, I like that as an example, the Kelly Blue Book of interface costs, of interfaces and their costs. I think that's...that's not a bad example, it's only a little bit out there, it's not too far out there. It's a little bit out there, I mean as one of those things which is, you don't really, you know we have to be careful, you don't want to end up in a place where, well, you want to end up in a place where you can actually be clear about what it is that you're selling obviously or what it is that you have, and it's not the same from one interface to the other, certainly not one vendor to the other.

But from the spirit point of view I can see, I can totally see what the...where you're going. All right, so the...then, but is it...are we pushing too much into this thing called enabling easier access, the ability to exchange data? Are we force fitting a bunch of things which don't really belong there? Open question, not loaded, I just want to make sure that we feel like we're being honest with what we said we...with what this point was?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

I don't know; this is Ty again and hate to monopolize but I think it's the elephant in the corner, right? It's the 800 pound gorilla in the corner that nobody ever really wants to address because it's so variant by vendor and yet it is the key driver to getting good interoperability or, in some cases, not getting interoperability at all on the part of the patient. So whether we're forcing it too early may be a good question, but we know cost is always either the number one or two barrier to all of this. I think literacy is probably battling right up there too, but cost is a big deal.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. All right.

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

I have one...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I...go ahead.

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

No, no, go ahead Janet...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Just real quick, this is Janet. I...the last point on there, there are issues that drive data blocking, inadvertent or not. That worries me a little bit because data blocking is such a loaded term and I think that people don't believe that data blocking can be inadvertent, that's how loaded it is. If we're talking about the pace or the spread of interoperability or the likelihood of making a connection or not or prioritizing connections or whatever it is, I'd prefer that we kind of frame it in those terms versus kind of using those magic words that make people immediately try to legislate things.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

I agree with Janet; this is Ty, because it's hard to get beyond those words. They're indelibly impressed in our mind now; I agree.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

I have a different issue with that same bullet that's complementary to this and that is, I'm...this is actually it just feels like a very vague bullet in the first place, even if data blocking was not a vague...was not a, to your point, a very loaded word. I'm not sure that this bullet really captures...I'm not sure what the spirit of this bullet is except that I know we had it noted down. How...is there anybody else who would like to kind of expound upon what we might want to talk about over here?

Anjum, I don't know if this came from your original notes or maybe Stacy from your original notes; I just want to make sure that we actually know what we were trying to say here and then to Janet's point, let's figure out some more neutral, productive words we can use rather than one that is automatically brings up a lot of connotation.

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

Yeah, this is Anjum; I think that that term was probably only used once in the hearing, so it wasn't like the term was used that often. I think the essence was for the several occasions where people talked about not being able to send data to certain providers around...you know just in our last joint meeting we heard about independent primary care physicians not being able to send data to hospitals and they were terming that as data blocking because hospitals are requiring that data to come through channels that they have rather than Direct and things like that.

So I thought that's what it was, so I'm fine with you know changing the term, but the essence was that there are occasions where it is difficult to either access data or send even data to other partners in the care team. At least that was my thinking.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Anjum and it really refers to everything above, right? It refers to all the bullets above.

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

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

It's really a description of what these bullets do really, in terms of what their net impact is; their net effect is that it creates, you know barriers and that increases the friction of being able to...

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

Yeah, I agree and so in some ways maybe this is redundant and, especially as we I think had the discussion about the first bullet and expanded that a little more to clarify not only just open API piece, but also in some ways the cost piece. I think some of that may also be a driver in this case.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right, right and I separated the APIs from the cost as Ty had recommended.

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

Yes, yeah.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right. Okay, anybody else have any comments or thoughts of what we should do with this, any other part of the spirit that...

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

Yeah, the bullet above had accepting direct communication from patients and other forms of patient-generated data. Wearables might be the worst example you can use because, you know that one I would remove and I would, just for example a perfect example is for people who are crus...you know, do a lot of procedures, it is not uncommon before you go to have your procedure for the patient to generate data entry, their history and physical, you know information on a, maybe a portal that that institution has and when you arrive there, that information has already been screened, viewed and transmitted to the individual who's going to actually be seeing you in pre-admission testing or what not.

So, you know patient forms, patient-generated data; when somebody...when the patient is the generator of that instance, to me that's patient-generated data, whether that's within clinic or outside of clinic environments. The wearable thing is just, that's just a disaster just waiting to happen because nobody...that's not stuff anybody uses clinically.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So wearables may be a broad term, maybe it's too broad a term for what's over here and there's some amount of wearables that are not used clinically, I'm sure there's some amount that are used...are probably even prescribed clinically, so they may be used clinically. But I agree that it's probably the wrong example use here. I'm not sure we'd actually need an example to be frank; I think people will generally understand patient-generated data and that it comes in a number of forms. So I'm happy to leave this without an example if that would be...that wouldn't bias the, you know an audience listening to this discussion. Is everybody okay with that if we drop the example?

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

Yeah.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. All right. All right, look, we are at about 20 minutes and so we will take a stab at these slides, we'll send them back, we'll definitely have...we will definitely have an opportunity to give us feedback before we give our initial draft presentation next Thursday. But before we get there, let's go to the next slide and actually let's, I just want people to know this slide's here, let's not spend any time because we only do have 20 minutes. This is the slide where we would capture some of the aspects. Let's make sure we add the note that Jorge brought up a lot earlier in the discussion which is that some of these things imply that there are other pieces that are available or that can come about, so if I wanted the exchange

bidirectional exchange, it sort of implies that I know how to reach that other provider I wanted to talk to.

We did capture some piece of that in bullet two over here around “root cause” analysis, but there are probably other caveats, points of view and so on that we’d want to capture here. I’m sure John Blair, as we’ve gone through the discussion there are certainly aspects that you thought were really important that just didn’t bubble to the top and we may want to capture that, you know it turns out they could be important in different ways. I think it’s fair to capture it here so send that to me and to me, Anjum and Stacy offline or to anyone of us offline so that we capture it here.

We will present it and if there’s something you send us that I don’t understand, I will come back to you to make sure that I do understand it so that we present it fairly. But let’s go to the next slide, in the 20 minutes we have left, really 15 minutes and change...

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

Can you go back to that one slide real quickly?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Sure.

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

It’s clinician-patient encounter; there are a lot of people that are, and it’s not about the physician.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Oh, good point, that’s at the last bullet, right?

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

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Great. Sounds good. All right, we’ll change that and let’s go back to the next slide...clinician-patient. Okay, I’ve got that, I’ve written that down as well. All right. So this is the draftiest of the draft slides, this one and the next two around recommendations. Around the ability to meaningfully utilize data, we’re...we’re trying to figure out what are some of those aspects we want to...what would we want to recommend to ONC?

What we did over here on this slide, and on the next two slides is we started creating recommendations at the top and at the bottom we captured...we sort of recaptured some of the things we articulated on previous slides. We may drop that bottom section altogether or incorporate it into another set of recommendations or we leave it as it is, as you know whoever takes the actions above, you know should probably think about a couple of the things we mentioned below. I’m not sure yet, but I did want to keep it all on one slide so that we could start thinking about what the recommendations would be.

The first recommendation that did strike us, based on the sheer frequency with which it came up is around what we will rename information reconciliation across interop contexts. This came up several times during our task force discussions; it came up several times from our panelists organically. So there’s clearly something there around what are the circumstan...I think it’s around what are the

circumstances under which information can be auto-reconciled; what are the behaviors you'd expect of reconciliation of data. And it cou...maybe it's around guidelines for what you'd expect as opposed to rules for how it should be done. But there is probably something there.

What do you guys think? I'm not sure that...first of all, what do you think of that recommendation and what do you think about other recommendations under this bucket called meaningfully utilize the data. This is the only one that concretely struck out to me as something needs to be done. I know I saved the la...the hardest thinking for the last.

George Cole, MS – Principal Scientist, Community Solutions – Allscripts

So it's George, just a slightly different perspective possibly on improve information reconciliation is we need to keep in mind, and I think it was I believe it was Steven Lane who talked about this, but others also is that you know there's a data tsunami that's happening so it's not just about the reconciliation, but it's about appropriately selecting the content that are relevant and need to be reconciled. It's about ignoring the noise and finding the key data.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Ignoring the noise and finding the key data; so how would we...how would you frame that in the context of a potential recommendation, George?

George Cole, MS – Principal Scientist, Community Solutions – Allscripts

Well, so I think...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Or is it a bullet below is what you're saying that it's not only reconciliation, it's about...

George Cole, MS – Principal Scientist, Community Solutions – Allscripts

...it's a key consideration, right? Not all data are to be reconciled.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. Okay, got it. Okay. Not all data to be reconciled, okay that helps. Any other perspectives? So just to remind everybody, we have the opportunity to suggest what future task forces may do, what we suggest ONC try to conduct, initiate on their own accord or what they should initiate in conjunction with other bodies, like standards bodies for example, or with other federal agencies. Of course it will be up to ONC whether they want to do any of these things, but it is...but that's what we are looking for here, what are some of the things which now that we've done this level of study together, what is it that we'd want to see happen to help push the ball forward in a way that's productive?

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

Yeah Jitin, this is John. I was just thinking about what George was just saying...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay.

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

...and you know the tsunami of data and the noise and what's pertinent to the clinician. You know when I think about how healthcare is practiced, there's hand-offs constantly, whether it's from the ED to the

inpatient or from the OR back to the floor or from the hospital to the community, hospital to skilled nursing, skilled nursing to ambulatory; and you know really we all learn in practice, whether you're in academics or in private practice or both, on how you handle those hand-offs. And it's a...it's just a small amount of information that probably 90-95% of the time we do it the same way and that's just the way everybody practices, whether you're in a great delivery network or out in the community.

And I'm just trying to figure out how you kind of build around the way clinicians communicate on all of those levels of transitions that are happening every day, all the time, everywhere. And I'm just thinking about that with George's comment that Steven Lane had said about the noise versus what's pertinent.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

John is it fair to say there's some, I'll use the word atomic and atomic might not be the right word, but some small number, some atomic subset of reconciliation worthy data elements? Is that what we're saying as well, and that might just be another way of saying what George was saying, but it's...that's where the focus should be? That if can figure that out and how systems can make it easier to do those things, then we will be in a much...we would get the most bang for our buck in terms of pushing the ball on interoperability?

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

Yeah, I...yeah may...yeah kind of; I mean I kind of look at it as concentric rings, I mean there's the key piece in the center which is always accurate medication that everybody needs as things move. And then as you move further out, you have subsets; for example when a congestive heart failure moves from here to here, there's 90-95% that every cardiologist wants, you know and then you move and you...you know, but there are so many different scenarios, but as you look at the different subsets, they're pretty consistent. But yeah, I think the answer to what you're saying is yes, I'm just trying to...I'm just thinking through the comments here.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup, yes, absolutely.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

This is Ty; also I'll throw out something different as a new bullet point, sort of a private and secure processing of the data and information as one of the elements, because as you know as we move to D-wave and processing speeds that move way beyond human to AI, I'm thinking more long-term, of course but adding in here that we are recognizing the need for that privacy and that secure processing of whatever we come up with on this task force or future task force.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right. Okay, so that's another part of the considerations, that there is going to be...there's going to be advancements in privacy and security that we will have to keep up with; all right, okay. Especially in light of where tech...both technology and, both...I'm sorry to say it this way, but with both where technology and crime is going these days, kind of important to be ahead of that curve.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Right.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. All right. Okay, there's another consideration there. This...in the spirit of ti...in sort of...I'll tell you what, let's go to the next one. If anybo...if it occurs to anybody that there's another recommendation here around meaningfully utilizing the data, which is where we spent a lot of discussion...actually before we go to the next slide, is there anything we'd want ONC to consider doing as an action item around visual design or goal-centered design? I always cringe when I think about the combination of government and user experience?

But let me be open, is there something we should be asking ONC to either do or maybe monitor or, you know, or maybe there isn't; I just want to be sure, because there seemed to have been a good bit of discussion around cognitive burden and these aspects. All right, let me put a couple of people on the spot, just to push this a little bit more because soon we're going to be having to talk to ONC and I don't want to sound, hey, we didn't think about recommending this.

Janet and Jorge, do you guys have any suggestions on this? How do you feel about what the role...what role ONC can or should play with respect to these things, user experience, visual design, goal-centered design and, you know the clinical burden really of the clinician using the...engaged in interoperability?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

So I think from my perspective, some of the things that ONC has done in the past that have been helpful have been around for example sponsoring challenges that allow for breaking new ideas and kind of pushing the boundaries of what can be done. Similarly some of the tools that they built SHARP C and like the framework that you could use in order to track usability testing was probably helpful for some vendors.

I think that trying to legislate or mandate usability to this point has not proven very fruitful and I certainly am not a huge fan of the government being involved in design considerations just because it moved too slow for what consumers and end users are expecting. So that's kind of my feeling on it.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, that's very helpful...thank you.

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

I...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Go for it Jorge.

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

Yeah, I agree with everything that Janet said, with just a few additional observations. The government has held, and Janet remember you and I presented way back in 2010 or 2011 at the NIST feasibility meetings for...and so the National Institute of Standards and Technology held for a number of years, usability focused workgroups to bring a level of social awareness to the topic and there was quite a bit of intellectual capital that was generated out of those sessions. So I think those are positive venues that, for example that's a role that ONC can continue to...ONC has been a participant in those meetings, and probably will continue to be a participant, so that's a role of keeping usability not from a legislative and mandatory standpoint, but from more of an educational collaboration, collaborative type effort. So I

think that one needs to, you know that needs to be highlighted as a role that certainly ONC and federal agencies and the private sector academia can certainly, because they were all part of the NIST meetings. So that's something that should be mentioned.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay.

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

There was one more and I just forgot what it was, but I'll think...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

If you recall, share it with us here or offline. Thank you, that was very helpful.

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

I will, I will.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Let me just preview the next two slides so everybody...I think we're going to run out of time before we can really go through it, but this is where we'd really love to get some more feedback. Syntactically and semantically interoperable; you know I just...as I'm reading this, so here's some recommendations we came up with. What's odd is that we didn't really discuss it a few minutes ago when we discussed what do those things mean, especially around social and behavioral determinants of health and how they should fit in.

I remember us having a rich discussion both at the panel and as a task force around it, so maybe there's a point we have to bring back into that other deck...sorry, into that other slide a few slides earlier, but one thing that we did posit, maybe there is a recommendation here around a path forward for bringing in that type of data. And maybe there's a...and maybe Jorge, probably I'll defer most to you over here, but there's probably some set of steps that is incremental to what's happened in the past, but needs to continue going on, in terms of the work ONC is doing with, you know NLM or others to continue improving the industry terminologies, code sets, etcetera.

What do you...we are almost out of time but in the next couple of minutes, what do you guys think of those two recommendations?

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

Yeah, I would expand the National Library of Medicine has been very strong in nationally supported terminology in efforts like the ones you mentioned, but I also think you need to include, industry standards like...terminologies that are being used in hundreds of EMRs across the country as an example.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay. All right. What do folks think about the first recommendation here is there something here or are we...or is this a puff of smoke? Is it something that's not really needed or is happening elsewhere I just don't know about? And I know we're missing the benefit of having the Larrys on the call today, so we'll posit it to them. But from the small and mighty group we have here, anybody have any...any thumbs up or thumbs down on that first recommendation as a starting point?

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

I think it...

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

This is Ty, no problem with it; the only thing I'm trying to look at is how do we add in NLP and this whole data mining stuff that's starting to filter through the lifestyle, environmental and behavioral stuff. So really going at the unstructured data, how are we going to bring that in to our world?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That's a really good point, maybe that's a key consideration as we think about this, NLP as a...all right, okay as an enabler for the social and etcetera. And somebody else had a point as well.

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

Yeah, I was just...I was going to say the same thing, how do you incorporate non-structured NLP analysis.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Perfect, okay. All right, Michelle am I right that we're out of time or do we have another minute or two?

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

You could probably push it and talk for one more minute.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, let's go for one more minute. Let's go to the next slide; I just want to make sure everybody at least has a voice over. Ability to exchange data and on this part, we thought there were some things already happening, but given the discussion we just had, there may be other things we want to add; so certainly when it comes to the open API work, there is open API work already happening as per the first bullet here under recommendation.

Under the second one, I think when we had our discussion, we didn't discuss it right now, so maybe it's not important but I think in our initial discussion we talked about how open APIs are important not just for EHRs, but for other types of health information systems across the care continuum, in other parts of the care continuum and I don't know if there's any guidance right now from the API Task Force as to what if other considerations we should be, you know should be thought about? And so that was a bullet we brought here which may or may not still be relevant.

And then finally, we thought maybe there's an opportunity for ONC to spotlight places where there's been successful incorporation of patient-generated data into the provider's decision making process that would be...that probably benefit from more people knowing about it; so more of a study than an actual task force or something.

So what do you guys think? Are these...is there any other recommendation you'd make over here? And certainly this has nothing...this doesn't say anything at all about cost transparency, either on interfaces or on...or to the patients, so maybe there's something there.

All right, I'm going to...Michelle, why don't we go ahead and move to the last page. I'm going to ask everybody to, now that you've had a chance to see the slides and we had a little bit of discussion, I'm

sorry we ran out a little short of time on the recommendations, but if you have thoughts, just shoot me...just shoot us a short email, happy to get on a call or if you have a fully baked thought you want to express in email, please send it to us.

We will take a stab at these slides by the end of the week and actually probably before the end of the week, and have them back to you so that you can take a look at them and know that as we go...as Anjum and I go next week to present to the joint committees, we really are presenting sort of the full point of view of the task force. We will start with your names on it, so please do give this good consideration. All right, Michelle, let's turn it to you so we have some open time.

Public Comment:

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

Okay, operator or Lonnie, can you please open the lines?

Lonnie Moore – Virtual Meetings Specialist – Altarum Institute

Most certainly. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the 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

While we wait to see if there is public comment, we did receive a number of comments in the chat that we'll send around to the group.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Perfect.

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

Excellent.

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

And just to reiterate what Jitin just said, if you all have comments, please share them with us and we'll do our best to integrate them into the PowerPoint and send it back out to all of you in preparation for next week's meeting.

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

We can also...

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

So it looks like there's no public comment.

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

If anyone has comment about the appendices that we want to attach to the slide set for the joint committees that would be also welcome.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right. All right, terrific, thank you everybody, appreciate the discussion. It was a small and mighty group and I appreciate everybody really jumping in and pitching in hard to get this further. We will send you an updated deck soon and look forward to any feedback you have before we take this show on the road, so to speak. All right, thank you all have a great rest of the week.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Bye.

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

Thank you and thank you Jitin and Anjum for getting us here.

Public Comment received during the meeting

1. Theresa Wilkes - AAFP: Data import - needs to include data provenance (data source attribution, date & time metadata)
2. Theresa Wilkes - AAFP: RE: Ability to incorporate the data into the EHR - In order to enable physicians & providers to truly utilize the data in a meaningful way, to impact outcomes, there needs to be an easy way for physicians/providers to "promote" various pieces of a structured or unstructured note (i.e. HPI, Social History, Medical Decision Making, Plan, etc.) into the receiving EHR system while maintaining source attribution. Lack of ability to incorporate specific pieces of medical records received via HIE results in merely ability to interoperably exchange clinical info that will then "sit" inactively in sequestered portions of receiving EHR's, which then does not become incorporated into frequently viewed info that would impact future medical decision making to enable improved outcomes.
3. Theresa Wilkes - AAFP: Yes, "Data Entry" is an interoperability discussion (rather than just an EHR discussion) in terms of the ability to enter data received via HIE via "promotion" of the data received (from a sequestered section within the EHR, to sections of the EHR where the data becomes promoted to be visible along with the native EHR system's data). If this "promotion" of data is considered a form of data entry (would assume so), then yes, data entry is a topic relevant to interoperability. Data entry is related to data integration within the EHR once data has been received and exchanged via HIE.
4. Theresa Wilkes - AAFP: There are both technical issues that result in inadvertent data blocking, as well as lack of awareness about HIPAA or lack of awareness about the fact that a physician/providers responsibility to safeguard the data ends once the data has been provided electronically to patients.

5. Theresa Wilkes - AAFP: Though it would be highly complex and the "owner" assigned to reconcile this would be contentious, it would be highly beneficial to be able to view all active care plans a patient has or carries, among all treating providers, as well as one "consolidated" & comprehensive care plan. If consolidation of care plans is not possible, at least transparency in all active care plans in an efficient way would be beneficial.
6. Theresa Wilkes - AAFP: If presenting examples of how PGHD was successfully incorporated by physicians into EHR data to positively inform or impact medical decision making and improved outcomes, it would be highly effective to also extend this to describe how each example helps the physician or clinician to meet MIPS or APM requirements (QRUR reports, etc.).
7. Jorge Ferrer: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1513664/> Interface terminology reference for consideration