

# Health IT Joint Committee Collaboration

A Joint Policy and Standards Public Advisory Body on Health Information Technology  
to the National Coordinator for Health IT



## Health IT Joint Committee Collaboration Interoperability Experience Task Force Final Transcript March 8, 2016

### Presentation

#### Operator

All lines are now bridged.

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a joint 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 will now take the roll. Anjum Khurshid?

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

Yes, here.

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

Hi, Anjum.

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

Hello.

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

Jitin Asnaani?

#### Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Good afternoon, here.

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

Hi, Jitin. John Blair?

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

Here.

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

Hi, John.

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

Hi.

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

Cris Ross is unable to join us today. George Cole?

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

I'm here.

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

Hi, George.

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

Hello.

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

Jane Perlmutter? Janet Campbell?

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

I'm here.

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

Hi, Janet. Jorge Ferrer?

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

Good afternoon.

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

Hi, Jorge. Kelly Aldrich? She's not able to join as well. Larry Wolf?

**Larry Wolf, MS – Principal – Strategic Health Network**

Here.

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

Hi, Larry. And Larry Garber?

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

Also here.

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

Hi, Larry. Phil Posner?

**Philip Posner, PhD – Patient Reviewer - PCORI**

I'm here.

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

Hi, Phil. Shaun Grannis?

**Shaun Grannis, MD, MS, FAAFP – Research Scientist, Director for the Center for Biomedical Informatics - Regenstrief Institute, Inc.**

I'm here, thank you.

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

And Ty Faulkner? We're working to get Ty on the line; I know he is online. And from ONC do we have Stacy Perchem?

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

Yes, I'm here.

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

Hi, Stacy.

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

Hi.

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

Okay, with that I will turn it over to our chairs and first let me thank both Anjum and Jitin for agreeing to co-chair this group for us. So let me turn it over to you guys.

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

Hey Michelle, by the way, it's Arien, I'm on.

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

Hi, Arien, thank you.

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

Thank you, Michelle. This is Anjum Khurshid. So I have the privilege of co-chairing this task force with Jitin Asnaani. I'm a Senior Strategist for Health Systems at Louisiana Public Health Institute and a member of the Health IT Policy Committee. So I want to welcome all of you to our first meeting of this task force. Let me say I'm extremely pleased to have someone with the expertise and passion of Jitin to co-lead this effort with me. For people who know him, his presence should give all of you the confidence that you are in good hands; the rest of you will find out about...during the course of this task force. I also want to thank all of you for your commitment to this task force and we look forward to input from you and learning from you.

I'm also very glad that two people for whom I have great respect and whose contributions to Health IT and I think interoperability in this country are well recognized, have joined us for this inaugural meeting. So I want to thank Paul Tang and Arien Malec, who will be joining us to give their perspectives to help us with better understanding of the charge of the task force. And Michelle, do we want to go around and have people introduce themselves or do we want to just launch into Paul's presentation?

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

Why don't we have each member of the task force do a quick introduction, just one or two sentences about who you are and we'll just go down the list so Anjum, I don't know if you want to say a few things and then we can turn it over to Jitin?

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

Sure, Jitin, it's over to you.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

All right, okay. Thanks. So I'm Jitin Asnaani, I lead the CommonWell Health Alliance and I'm a member of the HIT Standards Committee and I'm of course super-excited to be here and co-leading this with Anjum and with this outstanding team of folks who are part of this task force. The one thing I'll add about myself is, as many of you know, I used to work at ONC where I launched the S&I Framework with Arien and then was at athenahealth, so I played a vendor role for three years before joining CommonWell full time. So those are the sets of experiences I bring to bear as we go down our task. Maybe now we'll pass it on to Kelly Aldrich and just go down the list.

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

Kelly's not here so we'll go to John.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Oh yeah, Kelly's not here, that's right. Let's go to John.

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

Okay, thank you Michelle. John Blair with MedAllies, a health information technology vendor with several years' experience implementing electronic health records and over a decade, well, 15 years' experience in HIE and other interoperability modalities including running a Direct Network.

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

Thank you.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

Hi everybody, my name is Janet Campbell and I'm a software developer and Vice President of Patient Engagement at EPIC. We do electronic health records. I've met many of you over the 13 years that I've been doing this job; a lot of what I do at EPIC is this kind of work. When I'm not doing that, I focus on patient engagement.

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

And I'm George Cole with Allscripts. I, like Janet, I know many of you on this call. I've been involved in HIT for quite a long time. I currently work with the HL7 Structured Documents Workgroup. I am an IHE at-large board member of IHE International. I was on a previous FACA task force that Arien and Janet, had the pleasure to work with them and I also lead the Content Standards Workgroup of the CommonWell.

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

Thanks George, I think we got...

**Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University**

Hi, this is Ty Faulkner.

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

We did get you, okay, sorry Ty.

**Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University**

Oh, no problem...health IT 30 years healthcare, also a professor of Health IT where I teach data standards, networking, specifically HL7 and SNOMED. Thanks.

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

Hi, this is Larry Garber; I'm a practicing internist at Reliant Medical Group up in Central Massachusetts. We're a 500 physician practice and I led the implementation of our electronic health record and health information exchange activities where we focus on automating processes like automatically sending CCDs to the emergency room within 90 seconds of our patients arriving there. I also was the...one of the co-chairs of the S&I Framework Longitudinal Coordination of Care Workgroup that basically led to the Structured Documents Workgroup, creating the enhancements to the Consolidated CDA by release 2.0 and subsequently 2.1. So...and I'm grateful to be on this group.

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

Great.

**Shaun Grannis, MD, MS, FAAFP – Research Scientist, Director for the Center for Biomedical Informatics – Regenstrief Institute, Inc.**

And this is Shaun Grannis; I am the Director of the Regenstrief Center for Biomedical Informatics, a family physician and liaison to the Indiana Network for Patient Care, the country's largest and longest running health information exchange. I also serve as the chief architect of an international initiative called OpenHIE which is a health information exchange infrastructure implemented in West Africa, Rwanda, Philippines, South Africa...other...so we're working on repatriation of innovation of those experiences back to the US as well. Thank you.

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

Thanks, Shaun.

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

I don't think Jane is on so Phil?

**Philip Posner, PhD – Patient Reviewer – PCORI**

Phil Posner and I'm a retired cardiac electrophysiologist neuroscientist, a patient Advocate with the National MS Society and also with PCORI. I'm very involved with electronic medical records in my role on the Steering Committee with Care-Line Project, which is to work with older patients with complex medical conditions, dealing with multiple physicians from general practice to specialties who have to communicate with each other through electronic medical records, which don't always talk to each other.

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

Thanks, Phil. Larry Wolf?

**Larry Wolf, MS – Principal – Strategic Health Network**

Hi, so those who are paying attention probably notice that it now says Strategic Health Network next to my name, not Kindred Healthcare; I have recently gone out on my own. But speaking to the past, recent and otherwise, I was previously on the task force that Paul Tang will be reporting on, you know, what we need to do to move forward on interoperability. I spent a long time inside provider organization connecting to other providers, connecting through HIEs. I've got a long history of clinical systems development looking for Health IT to be broadly inclusive for all participants in health and healthcare. And I know several of you from my work at Kindred and elsewhere with MedAllies and Direct with Carequality, with the work that Larry did with a Learning Community in Western Mass on care coordination, Metro Chicago Health Information Exchange, so hopefully I can bring some of that real-world experience along with yours and we can really move this forward.

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

Thanks, Larry. Jorge?

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

Good afternoon, this is Jorge Ferrer; I am a Biomedical Informatician at the Veterans Health Administration. I have been in IT for almost two decades, initiated by a career in the federal

government...medical officer and I...to work on a number of initiatives there in health IT. And then I transitioned to the VA where I do a lot of work on usability, user-centered design and trying to improve the UX interfaces for the VA...medical record. I am still clinically active in surgery, so I get to actually see this every day, five days a week, 40 hours a week in addition to my Biomedical Informatics responsibilities at the VA. And I'm looking forward to participating; I know a lot of you by names, and I've also worked with many of you throughout my career.

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

Hi everyone...

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

Thanks, Jorge. Stacy, sorry.

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

Thank you.

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

This is Stacy; I am new to the ONC. I am really pleased to be here. I come from New York City working at the Department of Health at the Primary Care Information Project, advocating for EHR and HIT adoption to support Meaningful Use throughout New York City's providers, small practices, hospital systems, etcetera.

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

Thanks, Stacy and thank you everyone.

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

Okay, we can start with, you know, Paul. Paul is the Vice Chair of the HIT Policy Committee and we are really pleased that Paul could find time to come and talk to this task force, because he has been involved in this for a very long time with also more recently led the Interoperability...

**Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation**

Well thank you very much, Anjum. Let's see, could we go to the next slide, please...or hopefully, my...yeah, great, thanks. So I'm going to be talking about a report that Congress asked the HIT Policy Committee to produce. This is the membership of the task force that produced this report that was later approved by the full HIT Policy Committee. Next slide, please.

What we tried to do in the report were one, you know, oftentimes I think Congress and other folks who just hear the work interoperability think, oh God, that's a technology problem or a standards problem and none of the rest of us have anything to do with that. And so we wanted to educate Congress and others about the various barriers, what's involved in getting true exchange of meaningful information, not just technical interoperability.

So we wanted...and HIT Policy Committee and a number of workgroups have already reported on interoperability so we wanted to summarize that and then in particular, explore some of the financial and business barriers that illustrate the multifaceted barriers that do exist to meaningful exchange and make some near term recommendations. Next slide, please.

This is the text of the request over to the HIT Policy Committee. As I said, they wanted us to weigh in on, as you know, the Senate Health Committee had a number of hearings, I think six hearings on interoperability in preparation for legislation they would like to propose. Next slide, please.

So first, as I said, we summarized some of the past work that some of the workgroups have done in HIT Policy Committee. Next slide, please. And summarized those in three...in five categories. One is, well you can't have interoperability if you don't actually have these EHR systems that are based on standards. Second, there is a big operations workflow issues and barriers that impede interoperability; and that's a lot of what you hear from docs currently.

Third, privacy and security is both a goal, but also a very complex challenge. Fourth, the fact that we have to do all of this...not only do all the parties have to be involved, they actually have to be involved at the same time, and that has caused some of the impediments or the passage of time in order...between where we are now and reaching true interoperability. And finally we spent quite a bit of time on this is a lack of incentive. Next slide, please.

So I'll go over these five topics fairly quickly; it's well known to this group. Meaningful Use really has been very successful at going from zero to 60; now 97% of hospitals and three-quarters of docs have EHRs, whereas they almost didn't have them before HITECH. Everybody knows...and the challenge is that the interoperability between these systems has been slow; a lot is because healthcare itself is fragmented and consequently so are the systems that operate underneath healthcare.

Certification program has played a critical role in preparing us interoperability by setting some of the standards, but you really have a critical mass of folks, your clinical trading partners, have these systems that can talk to each other and want to. So one of the things that is going forward are APIs, and that's presumably thanks a lot to the work of the Standards Committee. Next slide, please.

So operations workflow challenges is something that isn't talked about as much, but is painfully felt by the providers who talked to us. When you interject new technology, a lot of it you see in iPhones in our daily lives but when it comes to exchanging health information, there's this complex workflow that is not standardized that goes on in healthcare provider organizations that get changed, and some people think it disruptive.

And so the fragmentation and the lack of standards in our processes actually make it hard to create information technology to serve those. We've been pretty good at starting to get folks to exchange information, but it's yet another plateau or goal to have people incorporate the information, actually one, view the information and second, incorporate the information into their record systems. Stage 3 actually concentrates on not only the exchange, but actually incorporating some of the information, hopefully meaningful information, into your own EHR. Next slide, please.

Privacy; well known that it is a sine qua non, we can't exchange information unless we can ensure adequate privacy and security protections. We know that electronic systems by definition, certified systems have to be able to do this but how they do it can be pretty tricky.

One, we...although in theory we've lived with these same laws such as HIPAA in the past on paper, in the paper world it's not very formally articulated and things don't go exactly as planned or exactly as policy. Well you really can't do that in the electronic world, so that's where...one of the places where the rubber hits the road and we end up with not knowing that we've covered all of the policy ground that didn't exist in the paper world and are not codified in the electronic systems. The other thing we're all painfully aware of is there are 50 state laws...50 states and they all have some or most of them have some variation in laws that you have to account for as you cross state boundaries. Next slide, please.

The next area is, as I mentioned, the need for synchronous collective action. We heard from a number of folks who, very well meaning, wanted to get their information from their institution, let's say a hospital, to the referring provider and found out that the referring, all of the different clinical trading partners weren't necessarily either on an EHR or on an EHR that could talk to the hospital EHR, in this example.

Well, some of the hospitals went out and actually had to do all the work for their trading partners in order for them to get credit for exchanging information. So this notion of everybody has to be in the same boat and implemented at the same state at the same time became a real challenge and some people had to go way out of their way in order to help with their clinical trading partners.

So it begs the question of needing some common, you'd like to have common rules of the road, not just some point-to-point, you know, hey you and I agree with something...on some policy, you'd really love for your whole region, and ideally the whole nation to have common rules of the road so that organizations and their systems could talk to each other.

So some of the...there's vendor networks that go from one vendor solution to another vendor's solution, same vendor, and then you have networks, regional networks that try to accomplish that last mile of inter-connectivity. So...but this notion of having to solve the problem at the same time with all of your trading partners becomes yet another pretty major hurdle for getting true interoperability to happen. Next slide, please.

So ideally we'd have sort of a common vision and a portfolio of HIE functions, again well known to the Standards Committee that would allow both the technical but also semantic exchange of information and really even more ideally, the exchange of meaningful information to this encounter for this patient. I think the next hurdle we have; we're seeing a lot of data exchange, but not necessarily even the clicks to even look at the data, let alone incorporate it. So we felt that the federal government plays a unique role both because it is a large healthcare provider and it also writes regulations and certification criteria in this example. Next slide, please.

So finally and most importantly, and we concentrated a lot on this, are the business barriers. So when we had hearings on interoperability, it turns out that there were area...some of the major barriers were either that vendors or providers actually didn't want to share information. Sometimes they felt that there was a perceived competitive disadvantage of sharing information. That of course gets in the way of good patient care but there are also perceived and possibly real financial impediments or disincentives to share.

So that became one of the things that has not, we felt has not been a focus of attention in the past and so we focused some of our recommendations in this area. At best the fee-for-service world doesn't encourage someone; you actually don't need to know what was done at another organization, especially

if you can do it yourself and get paid for it. At worst that would even discourage, actually, sharing information.

So the fee-for-service world did not turn out to be a good motivator, financial motivator yet in the new world, pay for value or just thinking of having better outcomes, you just gotta to know what's going on at all places where an individual is receiving care. And that's why interoperability is so critical to achieving the goals of ACA, for example.

We're very encouraged that already HHS is ahead of their temporal milestone that is they had expected to have 30% of the fee-for-service payment working through alternative payment models by the end of 2016; they've already achieved that now and the next milestone is 50% by 2018. So these are things that should be incenting sharing of information and having meaningful exchange. Next slide, please.

So we concentrated, the task force concentrated on these financial and business barriers. After having reviewed the standards, the workflow and other barriers, a lot of people have already talked and written about that and we've had hearings on that. So we focused more on the financial and business barriers, trying to answer these questions like, what are those. Which stakeholders are involved? What's the impact of having these barriers? How would we address them and who would be the most effective or influential party to address them? Next slide, please.

So we conducted a couple of virtual hearings dealing with these issues and, next slide please, and came up with the following four near term actions to accelerate progress, at least in our mind. Next slide, please.

First of all, found that the current so-called quality or performance measures generally, as is well known, are process measures. They are neither specific nor meaningful enough to really consumers...neither consumers or frankly providers look up the current quality measures to find out...to assess whether...assess the care or the quality of providers that are receiving those scores because they don't really address what we call measures that matter.

If a consumer is trying to decide what orthopedic surgeon to go to to have a joint replacement, the current measures are not going to guide them like, well how quickly do you return to work with this surgeon versus that surgeon? How's the pain relief? So on and so forth. So both consumers and providers really would benefit from measures that are far more impactful on the questions that they have, the choices that they are going to make.

As I say, the traditional measure developers are not really producing a pipeline of those kinds of measures. One of the reasons is there's no, you know in the past system they didn't really have a motivation; there wasn't really payment on the measures. Well in the new world, that's what we need to pay on and you'd want to pay on measures that actually matter to the people making choices.

Because there is actually not a big pipeline of these kinds of measures, not only do you want to ask for these measures, but you'd actually have to provide...somebody has to provide development funding to create these measures, because they have to be developed through a consensus process, they have to be tested, they have to go through endorsement; all of that takes money. Next slide, please.

So our recommendation is one that we look at meaningful measures that we called HIE-sensitive, health information exchange sensitive. So in other words, you could not score well on these kinds of measures

if you did not have meaningful exchange going on between your systems, but your organizations; the folks that are involved in the care of any individual patient. And that these outcome measures that are HIE-sensitive would be used for both public reporting and for payment, and that's where the money comes in. These would focus on things like coordinated care or affordable care.

So one example just sort of that we didn't drill down on the details, and of course that really matters when you create a measure, but the notion of let's say a payment policy was such that you would not get reimbursed for that procedure or that test if that wasn't medically a necessary duplicate. And the only way you would know whether it was duplicate is if you knew what other organization were making orders on this patient. So that fills the role of saying, you could not score well on this, and in this particular example you wouldn't be paid fully if you didn't understand what was going on with other people who touch this individual. Next slide, please.

For the second recommendation, one of the complaints we heard is well sure, yeah, they got certification in the lab, but they either it didn't work in real world or they didn't implement it or it was too expensive to implement. So that obviously became an impediment to true interoperability and meaningful exchange and we don't have a measure. So ONC and the certification bodies don't have measures that can be used in an ongoing way in the field to assess, look are the systems that are certified actually performing and good service in the field and there's no entity that's responsible for developing that sort of measure. So we both need to ask for those measures to be developed and to pay for them. Next slide, please.

So our recommendation was for the funding...to fund the development and use of again HIE-sensitive, but these would be sensitive vendor performance measures so that the public could understand, the prospective purchaser or the accreditor or the monitoring body could know are vendor products performing well in the field? For right now there's a lot of concentration on numbers, saying how many millions or billions of exchanges are actually happening, but that's yet another process measure, it doesn't assess whether we're having meaningful exchange, exchange of data that's going to impact patient care.

So you would take a set, not just a denominator of how many exchanges have happened, but how many have been viewed? How many have actually been clicked on? It turns out a very small percentage of...data that's been exchanged actually gets even viewed, let alone the third bullet which is, and actually used to reconcile, to update the records in the receiving party.

So we're imagining some...again, this is just an example, something like this which is going to measure not only did data flow from one system to another, but was it actually used. And over time, it would be up to the vendors to innovate and find usable ways, and that speaks to the Experience Task Force, usable ways where that information was easily accessible and answered questions that I was interested in. So that's the kind of thing we were looking for in recommendation 2. Next slide, please.

For three it's really to use measures that would accelerate, would really make the payment incentive palpable. So we heard again in our hearings that, you know we're on the right train saying we're going to go to pay for value, we all get that. What they also said is, but that's not enough to make board level decisions saying we are going to do this versus that priority.

So Meaningful Use had criteria, you knew exactly what you had to do in order to qualify for the incentive. That exact concrete, specific measure doesn't exist yet for the financial imperative and so

that's sort of what was being asked for so that they could make the decisions and prioritize things that would promote let's say, interoperability and more importantly, meaningful exchange. Next slide, please.

So our recommendation here is that major players, CMS and the private sector would have again HIE-sensitive payment incentives including the very speci...the numerators and denominator of the measures so that people would know and say look, here is the measure, it will be implemented in 2019 to give people a chance both to develop and test the measures, but also to implement them so that you knew exactly what you had to get done in order to get paid in the future.

Things that would prove that not only did you exchange information, but it led to coordinated, high quality, safe care; that you had shared care plans so that you could achieve the spec...the patient-specific goals for their health. That you took advantage of, we all know that what we do in the hospitals and doctor's office is such a small part of an individuals' health, it includes the social services out in the community. How do we make sure that those...the data is shared and that we're all operating off the same plan? How do you have close the loop?

So these are the kinds of measures that we're proposing that we actually prescribe or specify today to be implemented a few years in the future so that people can move towards that in a very actionable way. We also think that these...the measures that are applied should find ways to identify and to discourage and to punish information blocking activities. Next slide, please.

We...there have been many meetings and documents and action plans asking for health information exchange in the past several years, but a lot has changed since when they were first talked about years ago to the current situation where now the majority of the nation's health information are in health information systems. So they could be exchanged provided we have the right incentive.

We also talk about coordinated care or team-based care but really, and I'm an internist, the medical professionals and nursing...the clinical professionals haven't been trained on how do you put together an integrated plan that we can all coordinate our efforts around? So really...in other words, there are many stakeholders to meaningful health information exchange and coordination of care that don't know that they're involved. If people think of this as basically a technology or a vendor issue, it's missing the point of what we really want interoperability for. Next slide, please.

So what we proposed is that we do have, we called it sort of a working summit. It's not a summit of just vendors, it's not a summit of just providers; it's all the folks that need to be involved in order to get the end result which is coordinated health for individuals and communities. And so that goes from the educational, the medical schools, the nursing schools, the health professional schools all the way through providers and teams and hospitals and vendors, etcetera to get together and actually understand what does it take to truly have meaningful exchange for the benefit of improving outcomes.

That in itself would be a major goal of the summit, that is this sort of shared vision of all of the efforts that would need to come together in order to make care better, improve the outcomes. But also...so agreeing on a shared vision and agreeing on a set of milestones and some placeholders for the times would be just an enormous step forward that I think all these siloed activities are not going to accomplish in a short time; certainly not by the 2018 50% timeframe.

So we're really thinking that the federal...and only the federal government really can convene that kind of cooperated, multi-stakeholder summit, like it to be a combination of public and private. So the private sector...it would be nice if the federal government and the private sector both sponsored and paid for this summit and the work that comes out of this summit. And perhaps the FACA committees could provide a venue for their quarterly progress, and maybe there's an annual get together to check our progress.

But there aren't too many years that are going to be intervening between now and when we have to be 50% into the value-based purchasing by the end of 2018. So that's why we're really think...we think we need to call the question and have timely both agreement and milestones. Next slide, please.

So in summary, we tried to point out the various components of interoperability and that interoperability wasn't the end in itself. It's not as simple as say, as ATM and banking and yet this complex thing is so critical to delivery system reform. The current pace either our silos and our wishful thinking of trying to get interoperability on track isn't going to meet what we perceive as the timelines of delivery system reform.

So we think we need to have not a specification for each of the pillars let's say of interoperability, but really hold our very specific goalposts, objectives, a measure as the concrete goal where we're all motivated; everybody in the ecosystem, all the stakeholders are motivated to do everything it takes in order to get to that goalpost of better health for individuals and communities. So we think we have...we would like to prescribe these HIE-sensitive measures for both the care side, for the vendor side, and for the payment side, and really they're all in one, and bring together the multiple stakeholders to adopt that vision really and work on the plan that would get us from here to there. Next slide, please.

So I tried to go through this very quickly, it is available and may have been passed out...the final went in in December and happy to answer any of your questions. And hopefully this is helpful information to this task force.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

So...

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

Well thank you very much. If there are any quick questions for Paul, please.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

I have...this is Janet from EPIC. I have maybe part question, part comment. I think the idea of being able to bring together all of the stakeholders in this working summit is an admirable one. The thing I'm struggling with right now is that we're already participating in a lot of different summits that do this.

**Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation**

Right.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

As you pointed out, there are a lot of siloed initiatives out there and in fact now we're even more participating in the convener's of the convener summit, we're actually a level up and we're still doing

those plus the individual summits. And I'm wondering or asking, as we build towards that working summit, can we also look at it incorporating or starting to eliminate some of the individual summits that we're all working towards right now, with...I say that, but then at the same time I wouldn't want to lose the progress, the very real progress that's being made there. So it's a bit of a conundrum.

**Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation**

It is, and thank you Janet for pointing that out. I imagine this summit would have a lot of preparatory work up front and part of it would be to think just what you're thinking. We only have so many hours in a day and...but, just like you would in one organization where we all, you know, have these various committees and things, the com...the siloed committees just won't make progress as fast as some coordinated effort.

And I guess we're calling to question, how can we get all the effort we're already putting into it in a more coordinated and perhaps more integrated, potentially more rational view. And then even if we set those...the vision and the game plan together siloed, but perhaps better directed siloed activities can at least be pointing to that agreed shared vision. Do you see what I'm saying? So that's the hope and yes, it's a challenge but hopefully the integrated piece will make...we all...in our silos you all, one of the first activities is prioritize activities. Well, we're prioritizing against each silo and I wonder if we had some shared common objective, use case is one of those ways to describe it, that we might make faster progress and more productive progress.

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

Paul, this is Larry Garber, can I ask a question?

**Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation**

Absolutely.

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

So this is phenomenal work and I...it's all spot on. I do wonder though if, you know how much discussion took place about the ease and usability of the health information exchange. In other words, you're laying all the foundation that we need to be build roads and transportation vehicles to ride those roads, but those are horse and buggies right now. And we know that cars actually are much faster and get us to where we need to go much more efficiently with much less pain.

And it's if health information exchange involves, you know humans in the middle clicking buttons, selecting destinations from lists, sure, it physically can work but people won't use it and that so much of this has to do with making it easy, automated, highly usable and I didn't know if those discussions came up.

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

...actually there right now.

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

Yeah, thanks.

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

Sorry, that's actually my big transition to the intent of this workgroup; it's actually really good framing, but sorry Paul.

**Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation**

It's a great question Larry and is precisely the reason why we stuck at the high level, the HIE-sensitive measures. The reason is if we...an alternative, and just one alternative but maybe an extreme alternative is to say, let's certify whether you have good horse feeders. Let's feed the horses faster so they don't have to stop, using your analogy. That we didn't want to get into; instead we wanted to say, can we measure how fast, how safely can you get to destination B? And that's our...that's the analogy to the HIE-sensitive outcome for patients.

And let the innovation say, should we really have horses? Should we just feed them faster? Should we have skinnier horses, stronger horses or should we completely leapfrog and turn into these internal combustion and future electronic cars? But that's ex...the thought is that if we pinpointed, we focused on any one of these silos, whether you pick on vendors or standards or provider workflow, you would prevent the very breakthrough innovations that need to occur; so we focused only on the goal which is get to this destination and here's how you measure it. And so felt that everybody would have to...the designers, the people who drive whatever mode that is, would have to find better ways to get there. Does that answer your question, Larry?

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

Yes it does, thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation**

Sort of, it gives us a chance to say exactly what...

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

This is...

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

I like the skinnier horses idea that was good.

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

So Larry, that was a good segue to actually the next section, which...where we want to discuss the charter of this task force so, let me thank Paul again for his time and also for laying down a really good background in terms of, you know where we want to be going forward. Thank you, Paul.

**Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation**

Well thank you for the invitation.

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

Thanks. Can we have the next slide? So, before I hand it over to Arien in order to help us, you know set the stage for the discussions of this task force, can I have the slide where we show the charter, Michelle?

The charter of this task force, which has been given to us by the, Health IT Policy and Health IT Standards Committee is basically focused on improving the interoperability experience for providers and patients, which we just started getting into, and building recommendations for the policy and technical and other public private approaches.

So, before I ask Arien to really expand on this, I just also wanted to mention some of the thinking that, you know Jitin and I with the help of the ONC staff had come up with so Arien can also help us or guide us in terms of whether we are on the right track. Which is, as we think of what would be the scope of this task force, we are assuming that we are talking about providers, patients and stakeholders who have access to a system that can interoperate, so that at least one system is working with an outside system.

We did not want to narrow it every boil the whole ocean in terms of also thinking about where there is no interoperability at all, but really thinking of where there is interoperability, how is that experienced. And we know that in many cases that experience is not fulfilling, so what other factors then that we can help identify. And we also wanted to obviously prioritize and identify the few important needs for these stakeholders that we can...that are impactful and are also feasible in terms of being achieved and then make these specific and actionable recommendations for ONC. Next slide. Next slide, please.

And basically I think this is an easy slide in terms of understanding that there has been a lot of work that has already been done and a lot of tremendous work in the interoperability progress that has been made. But what we want to really understand is what is working in the field, what is not working, from the point of view of a fairly diverse group. And so all of you add a lot of insight into this work that will go back to inform I think national policy and standards. So, Arien, over to you if you can take this on and help us understand kind of the context of this task force.

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

Excellent. Yeah, the policy introduction I think was fantastic and really naturally led into the notion of the interoperability experience. The intent here behind the charge of this task force is really that we've...we're at Stage 2 of Meaningful Use against edition, I think 2014 certified EHRs, we're moving towards Stage 3. At the same time we're moving towards a Federal Health IT Strategic Plan and Interoperability Roadmap that have us go towards objectives like a learning health system in support of precision medicine in a landscape where, as Paul noted, we're moving rapidly towards achievement of alternative payment methodologies.

And it's a good time at this stage to pause and reflect on the experience of interoperability in the field, and by experience at least I mean and intend both the clinical experience and the operational experience. So clinical experience would address such considerations as is the workflow that is being used when we are able to achieve some aspect of interoperability, is the workflow clinically appropriate, clinically meaningful and is it driving the sort of practice patterns that are desired by the providers of care in the field?

And then the operational considerations might well be, can we achieve the outcomes that we're seeking to achieve? Can we achieve those at reasonable operating cost, both in terms of the direct cost of exchange, that is the cost of setting up and managing interfaces as well as some of the indirect cost of exchange; how much time, energy, attention goes into feeding the machinery?

The second, when you think about the notion of the Strategic Plan and the Interoperability Roadmap, we've often been concerned with interoperability as a general good, as sort of this magic general interoperability. I'd encourage this task force to look at interoperability as a set of strategic or foundational components that are more practical and constrained and drive meaningful outcome in some of the areas of consideration. Those areas might well be efficient operation and efficient delivery of care.

They might be improved delivery of individual care, and that's been the focus of health information exchange for so long that I'd encourage people in many ways to almost downplay that, not that it's not important, but that we always gravitate towards what's required to give a single patient an improved care experience. And think about some of these notions of improvement of operating experience and reducing the cost of care, as well as these...the notions of improving health populations, better managing the health of populations, better delivering towards the goals of precision medicine, better delivering towards the goals of alternative payment approaches.

So again, start with the end in mind. Use the Federal Health IT Strategic Plan and Interoperability Roadmap as a definition of the end in mind. Map back to the actual real-world capabilities that are required; to Paul's point, try to define those not in terms of hay and feed, but in terms of jobs to be done. And then detail from a findings perspective what's working and what's not. In the areas where it's working, what are the predecessor or preconditions towards success? And then in the areas where it's not, what factors are impeding the delivery of good experience, where again experience is defined both in terms of clinical workflow and in terms of operating, total operating cost, total operating efficiency.

And then as noted in the last bullet, there's an expectation that this group is going to spin-off more focused task forces to go address specific areas. So in the elucidation of findings and then making of recommendations, consider needs for spinning off more focused work.

And I guess the last point that I'd make with respect...or the last recommendation I'd make with respect to this group is that this is a group you just hurdled some of the resumes of some of the folks who are involved in this task force; it's a pretty amazing group. This is a time when we've all been involved in a variety of efforts, some of them are mid-flight. Some of them have enough legs under them.

There's no shame in looking at work that we've been involved in and concluding that the intent was right but the...but we have yet to achieve the outcome. I always remind folks that OAuth 2 took I think 35 revisions to finally get turned into a standard. Some of the sub-revisions were used in practice and had some wants and findings and OAuth 2 spun out of and came from OAuth 1, which itself had some wants and findings. So, we should take this opportunity to look at the work that's been done and see if it has some wants or needs to see if it's actually working in practice the way that we intended. And then use that experience to better drive where we're going.

And I think the last point I'd make is that there are some enabling, some key enabling activities for, for example, the APM track in MACRA or the MIPS track in MACRA and the timeframe to get through some of the policy development work that Paul was noting, as well as some of the standards development

work that's required is shorter than you would think. So I'd encourage people, again, to keep the end in mind, work backwards to findings and needs and then, you know even things that seem like they're ridiculously far away, even needs that seem like they're ridiculously far away, recall that it takes three to six years to go through a couple of cycles of health IT infrastructure improvement and adoption, so the time to start for those activities is now. And with that I will shut up and see if there are any questions relating to the charge for this workgroup.

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

Thank you. Any questions?

**Larry Wolf, MS – Principal – Strategic Health Network**

Hi, it's Larry Wolf; I'll throw out a comment, something I think I'm hearing consistently both from Paul and from Arien that I want to reinforce. Sometimes it goes under the label of bright spots or successes; it's very easy to find like the next thing we need to do or how to make something better but I think we often lose sight of, and as Arien was saying, where things work, what were the key enablers that made them work? And so I'll just, I'll grab a couple of examples that are sort of in some ways obvious, but I don't think they're necessarily gratuitous.

So we have ePrescribing; some things work really, really well, some things really don't work at all, if you look broadly at what the vision of ePrescribing might be. So there might be some lessons to be learned in the details of how that actually works. There is also a whole lot of effort in the last year or two to get admit/discharge notification into managed care, ACOs, care management, whatever the care coordinating organization is and that's often building on sort of the very not dramatic area of, you know HL7 version 2 admit and discharge messages that have been in place for decades.

So I think there are some lessons to be learned there, particularly on, so how does that then play forward into actually engaging patients and changing their care patterns, engaging clinicians in making use of this information because I think getting that loop closed of where are the clinicians engaged, where are the patients engaged, is really sort of the pain point that people say when they say interoperability isn't there is where is it actually working and how do we build on those?

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

Any other questions?

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

Yeah, I'd also note, this is Arien; I would also note that there are areas where something is working but its working in pockets. And sometimes its working in pockets because it's just it works and it just hasn't scaled. And sometimes its working in pockets because there's something special about that pocket. And in health information technology in the past, we've often wanted to make the claim, because we're so passionate about this, that X works and point out a proof case where X works as if X works so therefore everyone should do it is true.

In some cases it's worthwhile looking at X works and ask the question, what's special about that pocket? Is it because there are different business models in play? Is it because the actors who were involved in X have nailed out, you know, nailed some of the details and that's a precondition for success? So I'd encourage people to look for those bright spots and then ask the question, not this an existence proof

and we can just scale this out, but ask, what is special about this bright spot? And what's required to take this...to nurture this bright spot and make it scale?

There was another example we have, individual networks or individual EHR vendors that have worked out in many impressive ways the workflow associated in interoperability. Is that simply a matter of just do this for everybody or is that a matter of, okay, what are the special conditions that applied there and do those special conditions apply for the whole ecosystem? If not, what needs to change to make all of that scale?

**Larry Wolf, MS – Principal – Strategic Health Network**

And, so Arien, I really want to double down on what you're saying because I think that's really important that we look at the special conditions. But I also think we need to use that as a lens to separate, perhaps, the functional achievements from the technology it relied on. And I'm reminded of an old math teacher who used to say, first proofs are ugly, it takes two or three generations to get beautiful proofs and that in many ways we're sort of in that place here, right? We have things where people go, oh yeah, right, that's how it works but God, it's so much work. And we need to work on getting it to scale, we need to work on those beautiful proofs, and they're not just as simple as cookie-cutter the thing that's there. So thanks for bringing us back to that.

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

This is John Blair, can I just make a comment on I heard to amplify on some of these comments and then make a comment on workflow?

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

Yes, please.

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

Okay. So, I'm thinking about all I've listened to here and just a little bit more background. We're involved as faculty on the Comprehensive Primary Care Initiative for the New York region. One of the milesto...so, when you get to alternative payment and CPC, one of the milestones is on transition of care and care coordination. So some of this workflow conundrum, and some of the difficulty is not even around the technology; it's now starting to get disparate siloed organizations to work with each other, separate and distinct from technology.

And I'm thinking specifically about what we've done in the last year in the region on transitions from the acute setting to the ambulatory setting. And the person that runs this, some of you know her, Holly Miller, has developed checklists for transitions from acute to ambulatory for the nurses. So now, today we have a nurse-to-nurse handoff that happens between the hospital and the primary care practice in our region for CPC.

And just getting a nurse-to-nurse handoff before this happened was a Herculean effort; so that was a workflow effort that had no technology associated with it. And that checklist dealt first and foremost had a reconciled medication list that was critical for that. So there are two things that happen now on every discharge on a high-risk patient in this region; there is a nurse-to-nurse handoff with a checklist that takes about 10 minutes and then there's an appointment made within five business days for those high-risk patients. With that, we've had a dramatic, dramatic effect on readmissions.

Now with that, they then had to get a document transferred from the hospital to the primary care practice. That then drove the technology, and I mentioned at the beginning that we operate a national Direct Network, so we know what the traffic is nationally. By implementing that workflow, which had nothing to do with technology at the time, we see a 10-fold increase in transactions for Direct in the network in this region. So the workflow issue is not always around technology, there is...there are workflow issues around the siloed healthcare stakeholder groups now that they're having to work together under the alternative reimbursement models and the things that are coming out.

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

John, thank you, that's a great point and actually it helps in transitioning to the last sprint in our meeting today which Jitin will lead, in really thinking about what would be the framework in which we can address some of these things that Arien and all of you were kind of discussing, where are the bright spots and where are things where things are working just because of special conditions? So, Arien thank you very much for giving us a good background on this and Jitin, over to you.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

All right, thank you. I suspect we'll be tapping into Arien's wisdom a bit more over the next 30 minutes. So when, as you guys all know being mostly...most of you are veterans of these task forces, there is a little bit of magic and a little bit of art that comes towards actually creating a task force and outputs of a task force that's useful. I'm a master of neither the magic nor the art. So one of the things that we started out with when Anjum and I met during this pre, you know, the crazy pre-HIMSS period is we said, well what might the output at the end of this workgroup look like.

I think right now the discussion which we just had that Arien kind of spearheaded for us around the task force charter has given us some great ideas for where to start, and so we'll go back to figuring out how do we think about...how do we get this group to work through what are the jobs to be done? What are the opportunities for bright spots and the collection of different types of operational, you know learnings which we have, a la what John Blair just shared, that can influence us to the right outcomes. But if we start with sort of the end in mind of what we want to produce, at least it will kind of give us some clarity what we're driving towards. Let's go to the next slide.

And so this is as much as a question for Paul and Arien as it is, you know sort of an articulation of what Anjum and I were thinking in conjunction with our ONC team, who has set us up really well over here. If at the end of this task force, I think what we said is we want a couple of things to be clear; we want to have outlined for those organizations or situations where there is interoperability available, what are the needs that allow, actually allow us to take the next step in saying that this interoperability is enabling, you know real world change in care, positive impact in care as well as, what are the things that we need to do to get to address those needs.

So thinking of those as two discrete components, first what are the needs? Clearly as we work through situations that require interoperability, we'll probably run across three different types of scenarios; places where there are needs which are not at all being achieved. Needs with clin...and when I say needs I mean clinical, operational and there may even be other flavors beyond those two buckets that Arien outlined; but those needs which are partially achieved, but there are still significant obstacles that we have to figure to work through. And then the, I think it is actually worthwhile calling out those places where the needs are fully addressed.

I think Paul said towards the beginning of his articulation of that report that ten years ago or maybe even five years ago, there was...and the first big need was that there was just no place for electronic data to even be stored. Whether Meaningful Use was a perfect program or not, now there is a place where electronic data is actually captured and that's where the bulk of it is captured, in the EHR and so now there is a starting point. So we can at least say that at some degree that need is being met; not that we have to start with that, but there are probably a number of things which at this point we're taking for granted as we look forward and they probably only occur in certain spots.

So one potential outcome of this workgroup could be something like this table at the bottom, which is just meant to be illustrative, just to help us kind of think about what it is we're going to produce at the end, you know essentially a list of needs and to what extent they are being achieved and the extent to which they're important or not for better outcomes in care as Paul articulated.

Let's go ahead to the next slide; and this is just a two slide sort of illustration where I think we want to end up. And so if we had that list of needs and from that we were able to extract those which, you know obviously the met needs are the met needs and they're good to articulate, but the place we want to focus on are those which are both important and not being met.

And then we can look at what are potential solutions for getting there. And those solutions would probably; you know there are probably a couple of different attributes of those solutions. One is, are those solutions, are they working broadly but they need broader adoption? In other words, some of those bright spots, is there an opportunity to borrow from them and take them more broadly? What's working specifically in specific pockets? Maybe that's actually more the bright spots example, actually.

And then the third one is, what is it that maybe we shouldn't be focusing on the horses, we really do need something that is a step change from where we are right now. And we can think about it and we can...and to Arien and Paul's point, it's something that seems five or ten years away, but if we don't get started now, we'll actually never get there.

So those are maybe the types of solutions which we want to articulate. At the end of it, it's going to be about what's the adoption of those solutions, the feasibility of executing those solutions and then recommendations back to ONC in terms of actions they can take to make those...to help drive those solutions to reality. That's the sum total of what Anjum and I thought about as the potential outcomes coming out of this workgroup; I'd love to hear both from these workgroup members as well as Arien, and I don't know Paul if you are still here towards the end. I'd love to hear if this roughly encapsulates where you think we should go and what we need or whether you'd suggest something slightly different.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

Hey, Jitin.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Yup, who is this?

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

This is Janet from EPIC.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Okay, Janet.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

Two things I was thinking about just looking at that; the first one, I think it would be also useful to crosscut those needs with the stakeholders that have those needs, especially because we may find that stakeholders have conflicting needs and we'll have to kind of surface that and decide what to do about it. And then secondly, too if we look at the solutions, it would be useful also to list the players that will have responsibility for that solution.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Great points, both great points. Actually, the crosscutting with the stakeholders, we'll...as we start diving into articulating the needs, we...Anjum and I had some ideas of where to start and we've kind of implied it over there, but we've not called it out over here so I think we're already in sync. Solutions and who owns them is a really important point which we've not spent a ton of time thinking about so far. Terrific; thank you, Janet.

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

This is John, this is a que...so who owns them in terms of developing and rolling it out or who owns them in terms of usage?

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

I think we prob...my guess is we probably want to articulate both. At the end of the day it's good...it would be, in my mind, usage of anything that's...any solution that's created in the context of broader clinical care. But you can't get there until you know who is responsible for creating them so I think you have to kind of do both in order to get to the bigger picture. What do you think, John? Did you have a thought in mind specifically in terms of where this focus should be?

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

I think both, I think both. Sometimes we infer usage and we may not be right about that as we actually put it into production.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

That's a good point. Any other comments? Arien, I don't...I'd love to hear if this is in the direction that the...was intended.

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

Yeah, I think this framework makes a lot of sense. I'd encourage maybe a couple of things. First of all, with respect to needs; if you can put together, and I hate to recommend this word, but if you can put together like an ontology of needs or map the need back to aspects of the Interoperability Roadmap or the national priorities. For example, needs that are meaningfully required for achievement of alternative payment methodologies, for example measuring clinical quality across an ACO population might well be a need. To the extent that we can see the tieback between, and maybe that's what you meant by need and then your solutions are subservient to that need.

The second would be to consider maybe a couple of interim deliverables, because I expect that this task force is going to be...is going to have some...is going to be around for a little while. Think about what interim delivery might be and how you can check in and course correct, and that might mean making sure that you've got an appropriate elaboration of the needs and solutions, that there's a time to talk about findings before you talk about recommendations.

And then with respect to the charter and charge, don't necessarily think that you need to solve all of the needs yourself; consider and contemplate times when the appropriate thing is to spin-off a task force to think about additional findings and recommendations with respect to a given set of needs and solutions.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Got it. Actually, that is probably a really good set up for the last slide on, I guess, our last ONC-facilitated slide on where we think we need to go with this workgroup. So, looking at where we are right...today of course we had a...this is our kickoff for this task force. We have a couple of folks who will join us for subsequent meetings who are not able to make it today and so we'll be debriefing them in between.

But on March 23, we pick up...we are supposed to pick up with planning for virtual hearing panel discussions; Arien, to your point there, we'll probably need more input, not just within this group, but beyond this group. Anjum and I at least thought that we probably want to start the discussion on needs before that time so, I'm not sure we're going to be able to start it in any meaningful way today, we might decide to carve our more time at that next meeting to start making some headway on the needs and then look at...and then start figuring out who the virtual panels could be.

And then getting input from broader community over the April meetings, before going through summarizing discussing needs and potential solutions that we identified at the May 6 meeting, drafting recommendations, continuing to refine the recommendations, presenting to HITSC and HITSP, getting back feedback so that by the...our aim is that by the July 12-13 joint meeting we are recommending...we have a recommendation on both the needs, solutions and actions for HITSC and HITSP...sorry, I'll just call it HITSP, I know it's HITPC, and a transmittal letter sent at the end of July to the National Coordinator.

This is the draft work plan. I suspect we'll do some offline work in between now and then, given how rich this topic area is, but I would love to hear if anybody else has any feedback on this plan.

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

This is Larry Garber; there are tons of needs that we could be discussing at our next meeting. You think that we should be doing homework and maybe do some consolidation and perhaps you can remove duplicates and then sort of lay those out for us for the next meeting?

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

I think that is a great idea, Larry. One suggestion I'll have is, we do have...Anjum and I did think a little bit about where we would want to focus, and so happy to show that on the next slide, let's just go to the next slide for a moment. The slide after; this is probably where we were going to kick off on the next meeting, but we started thinking a little bit about it beforehand.

What if we started with an example, an example that'll just help us to, you know, the catch with a task force is that we're obviously on the hook to try to figure out something...figure out recommendations that are broadly applicable or applicable to a broad enough audience to be of value nationally, but actually come up with something concrete that you can actually say that this was an insight and a piece of work that otherwise could not, you know, you couldn't just copy paste from pre-existing work and say we are done. Something that is actually valuable and original.

So our approach was what if we started with an example, just to make it really concrete. And I agree, Larry, what if we took something like this, an example like this if people like this type of example, a patient the chronic co-morbidities such as, let's pick a diabetic patient, what is experience for the

primary care provider, for the patient and for maybe an additional provider such as a renal specialist. And then think about what are some of those, you know in our mind when we cobbled this slide together we thought maybe those needs for that patient and those providers.

I like the way Arien framed it right now, maybe more than needs, another good way of terming it is, what are those jobs to be done for this patient and providers? And happy to consolidate some of that offline so the next meeting when we get together, we have an amalgamation of ideas from members across this committee. Larry, does that make sense?

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

Sure it does and I guess one thing I do wonder, you know, when you talk about solutions, some of those are perhaps more catalysts and maybe you can correct me if I'm following this wrong but, let's say in this...in a scenario where this patient is shared let's say between a primary care provider and a specialist and when, I'm an internist, I'm a primary care provider, and when my patient sees a specialist, I want them to be able to send information back to me summarizing their plan.

In order to...so my need is to receive that consultation note into my electronic health record from the specialist. But in order to catalyze that, the specialist needs to be able to access a provider directory to be able to find me and to be able to know how to get that information to me. So my need is the data; the solution or catalyst is a provider directory, is that where you're going with this?

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Actually I'd like to take that up a level to both Arien and Anjum. In my mind, that is a part of the solution and so there's...

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

Yeah.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

...it is worthwhile to call that out as an infrastructure piece that is req...that is needed. I'd love to hear, Anjum and Arien, if you have...how you guys think about it outside of the sort of the narrow infrastructure box in which I live.

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

Yeah, this is Anjum, I think that's very much on target and provided that actually might be one of the jobs that is needed in order to fulfill that need. So I think that's where we have to prioritize and then see what, maybe there are two or three solutions that fulfill a need and what those solutions would be, as we try to make it more practical. So I think that was a good example of how you want to make it real in terms of thinking of solutions.

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

I would in general say that despite the name of the HIT Standards Committee, we sometimes over-focus on standards and under-focus on some of the enablers that allow those standards to work, where those enablers can be infrastructure, they can be policy and network development, they can be business models and the like. So, to the extent that we can draw out the key enablers that are some of the predecessor success factors for achieving the jobs, I think that would be fantastic.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

All right, terrific. And then on top of that I'd say they, you know Larry, even in that solution they may be...sorry, in that particular example that you gave, there might actually be other pieces to that solution that are clinical nature, operational nature that need to dovetail along with yeah, the technical solution that is a provider directory for it to really work, not just for it to be an enabler, but for the solution to actually come together you need those pieces...you need all the pieces usually come together in a smart way.

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

Agreed.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

I think articulating that would be valuable.

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

So Jitin, this is John; are we going to work off this one example or are you thinking of having additional examples?

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

John, the real answer is open for suggestions. The way Anjum and I thought about this, and Anjum, you correct me if I'm wrong; if we started with one relatively concrete...with one concrete and relatively generalizable example that we can quickly get to a good set of needs, which don't necessarily only work in that scenario, but open to other ways. One of the things that strikes me, even with this example is from a purely technical point of view, there are a lot of different big jobs to be done in terms of pushing information or pulling information or subscribing to information, so it still leaves a lot of flexibility there. But there could be some very different clinical scenarios that have similar infrastructure pieces and we'd be missing that insight by sticking narrowly to this example.

**M**

(Indiscernible)

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

Yeah so...

**M**

I think the bottom line on this is...

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

I think somebody's trying to speak but you're very, very distant, whoever is trying to speak.

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

John, go ahead.

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

So this, yeah, so this is John. So I'm fine with this one example, I would just...the only reason I asked is that, I mean I've been living for the last 10 years and working with Geisinger and what they do in an integrated delivery network because a lot of this interoperability is just part of an integrated delivery

network; they're all one system. And we then deploy a lot of those principles in an open community and so, this example is a good one on the ambulatory side with primary care and specialist.

The only thing I was going to suggest if we were going to do other examples is the acute to skilled nursing to ambulatory, particularly if you add home health because that ties all...it ties all of that together and may bring in some more infrastructure considerations. So again, I don't want to weigh this down if you were just going to stick with one, but that would be another thing to think about.

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

This is Larry Garber, I agree with John; I think we do need to stretch a little bit more and make sure we cover a few more use cases so that we do make sure that we're not missing any of the catalysts for the healthcare system.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

This is Jitin; I think that's a great idea. One question for you guys is, do we...is there an example out there that can help us tie those together smartly that's better than this one, that replaces this one or is it really that we need multiple examples? I'm just trying to get the balance between generalizability and concreteness. But I 100% agree that it can't just be ambulatory ambulatory, that's missing both acute and post-acute and those are critical.

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

And...

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

So Jitin, I...we've got a little PowerPoint that Holly has that kind of does what I'm talking about. I'm happy to send that over to you and it just...it has those different arrows. You may want to not use that or you may want to replace with that, but I mean if you want that, I can...I'm happy to share it.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Okay. All right, that's terrific. Here's what I suggest, since we're almost at the bottom of the hour and we should open up for public comment, why don't we do this, John, if you...why don't you send me that; if anybody else has any suggestions, please send to me and Anjum by email. We'll put it together, Anjum and I will debrief and we will use that, if it turns out to be one example great, if it turns out with multiple examples, that's fine, too. And we'll send out a framework which people can use to just provide some input back, which we can consolidate.

Certainly a lot of the interesting material will come out of our discussion when next we meet. If you can do a little bit of homework, especially since we have two weeks before the next meeting, then we'll have some good material off of which to drive the next meeting and get us more quickly to the place where we feel like we're getting some insight.

**Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation**

Hey Jitin, one more thing to keep in mind as you're putting together the spreadsheet and these use cases, which I love is, just a plea to consider the smarter spending and healthier populations portion of the Triple Aim and include in the healthier populations some of the precision medicine care abouts or learning health system care abouts; so, not just how do we apply best practice to a population, but how do we improve the care for this population. So again, just as a plea to almost deliberately not over-

rotate...restrain ourselves from over-rotating on improving individual care, even though that's correctly important.

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

Got it.

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

That's...I think that's a good, a very good point.

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

Yeah, agree.

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

This is Michelle; can we open up to public comment soon? Sorry.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Yes.

#### **Public Comment**

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

Operator, can you please open the lines?

**Lonnie Moore – Virtual Meetings Specialist – Altarum Institute**

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

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

And while we wait for public comment, as Jitin said, we will regroup after today's call and probably develop a little bit of homework for folks and maybe a new plan for our next meeting, because we didn't cover everything we were hoping to today, and we'll share that with all of you.

**Lonnie Moore – Virtual Meetings Specialist – Altarum Institute**

Okay and it appears there are no comments at this time.

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

Thank you, Lonnie and thank you everyone for joining this first call. We really appreciate you being a part of this group.

**Multiple speakers**

Thank you.