

# Health IT Joint Committee Collaboration

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



## Joint Health IT Policy and Standards Committee Interoperability Experience Task Force Final Transcript March 23, 2016

### Presentation

#### **Operator**

All lines are now bridged.

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

Thank you. Good afternoon 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**

Hi, Anjum. Jitin Asnaani?

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

Hi, here.

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

Hi, Jitin. John Blair? Cris Ross? George Cole?

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

Yes, I'm here.

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

Hi, George. Jane Perlmutter? Janet Campbell?

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

Here.

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

Hi, Janet. Jorge Ferrer?

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

Here.

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

Hi, Jorge.

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

Hi, Michelle.

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

Kelly Aldrich?

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Present.

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

Hi, Kelly. Larry Wolf?

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

I'm here.

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

Hi, Larry. Larry Garber told me he'd be a few minutes late. 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**

Hi, Shaun. And Ty Faulkner?

*Inaudible audio background noise*

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

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**

Anyone else from ONC on the line? Okay, before I turn it over to Anjum there is somebody with some background noise if you could please mute your line that would be greatly appreciated. And with that...

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

Michelle?

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

I’ll turn it over to Anjum.

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

Michelle, this is Larry, I’m on the phone now as well, Larry Garber.

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

Hi, Larry.

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

Yeah.

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

Thank you.

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

And Michelle, this is John Blair.

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

Hi, John, thanks for joining.

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

Okay, thanks.

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

Hello, everyone, this is Anjum Khurshid I welcome you to this second of our meetings. We plan to basically revisit and just review the Task Force charge from our previous discussions and then just get into really the details of the discussion today which will be around, you know, use cases and talking about the needs framework two documents that had been sent to you via e-mail but we'll be discussing them in more detail and then some of the, you know, next steps and public comment. Next slide.

So, as you see we have...I mean, we're very pleased that we have such a diverse group of experts on this particularly I want to point out that, you know, we have two patient advocates on this Task Force which, you know, ONC has been...for the last few years has been focusing on patient engagement and patient centeredness in our strategies and I think this is a good example of, you know, having patients at the table to be discussing things that relate to patient outcomes and then in addition obviously we have a very, you know, a set of experts from different parts of the health sector which then this Task Force to be able to cover several aspects of interoperability experience as we discuss this and we are very glad to have obviously our federal partners and ONC staff that has been extremely helpful in moving this along. So, next slide.

So, as we have discussed last time and I think we were fortunate to have been joined by the Co-Chairs of both the Policy Committee, Paul Tang, and the Standards Committee, Arien Malec, I think they shared with us their view of what is expected for the ONC for this Task Force, again, basically focusing on recommendations that will help improve interoperability experience for providers and patients.

And again, we had looked at some of the details of what are some of the boundaries that we had agreed on in terms of really looking at interoperable systems and then coming up with three to five, you know, most prioritized kind of list of needs in order to improve that interoperability experience in ways that are impactful and feasible, and then come up with recommendations to ONC that can be implemented. Next slide.

And I think one of the key things that I got of comments from both Paul and Arien in our last meeting where that they were almost suggesting we use the interoperability roadmap and the HIT strategic plan as the end and then map it backwards and see what is it that is needed to reach that end whether that end is related to valued-based systems or more patient centered outcomes.

And then really think of what are things that work well and what are things that are not working well and drill down into what are some of the preconditions that allow for successful interoperability and then what are impediments of values to that interoperability experience. So, in that respect I think that

to me is like one of the key things that we have to focus on is really prioritize on where interoperability experience is fulfilling and where it is not and then what are the factors that are affecting it.

So, as we then send our recommendations it would be great to come up with, you know, some suggested solutions where at the same time I think we have the opportunity to also identify things that may require a deeper discussion, a longer time to develop those solutions where we can suggest or recommend even further, you know, workgroups to focus on some of those aspects that may require more detailed discussions.

But by and large I think our task is mainly to identify where the interoperability experience is working well and where it is not and then drill down into what are the factors that would lead to success and what are the factors that are barriers or impediments to that goal and then how to go about addressing that.

And today we want to spend most of the time really hearing from you in terms of your ideas and suggestions on how we go about that. We obviously want to not get too far into the solution's piece because I think we will have subsequent meetings where we can really focus on solutions but I think at today's meeting if we can at least list some of those needs and understand some of the granular aspects of those needs for interoperability that would be great.

And we had presented a framework in our last meeting which I think I'll let Jitin actually lead that discussion as we try to make further progress on this. But again, thank you very much for your contributions we have already received input from you via e-mail so we encourage you to continue to engage us with ideas so that we can make these meetings more efficient and valuable for all of us.

So, if there are any questions on at least the charter and the charge that we have I'm happy to talk about that otherwise we'll move to the next stage of the discussion.

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

Anjum this is Ty Faulkner, could we add one more roadmap that's more clinical in nature, the leading health indicators from Healthy People 2020. I realize this is an interoperability group but I think being able to bounce off some of these targets around the LHIs and sort of what are our goals from a clinical stand-point might be helpful as well. Interested in what you think about that as well.

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

Yeah, I think that's a great point and I'll see if anybody else has any comments on this?

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Hi, this is Kelly Aldrich...

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

Yeah, it's Larry Wolf, I like that.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

I think it's a good idea. Another direction that we might want to look at is what are the quality reporting factors because as our health systems in the continuum of care relies on reporting into that I think that it could help feed that Healthy 2020 it might be a nice balance.

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

I have a question, by clinical do you mean the clinical utility at the point of care?

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Yes.

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

Okay, you might want to make that distinction because if we don't then the value proposition for the end-user is missed and I think that's a missed opportunity for these types of initiatives.

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

Agreed.

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

Hi, this is Michelle, just a reminder if you could state your name before speaking that would be appreciated, we're just getting to know voices...

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

I'm sorry.

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

We don't know all who everybody is. Thank you.

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

That was Jorge, I'm sorry.

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

Yeah, this...

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Thanks, Michelle, this is Kelly Aldrich again, I do have a question for the group and I noticed that the use cases that were submitted are role-based. Do we have any guiding principles to state that we'll look at things such as patient centered outcomes as opposed to perhaps role-based which might get us farther as we talk about the patient outcomes and the impact of informatics to them.

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

You know that's...this is Janet, that's an interesting point but I do think that we also like maybe both cases, we could do kind of a crosscut or something like that because ultimately different user groups

represented in the scenarios are going to have needs in order to get to those things anyway and having the role-based assessment of needs I think still remains important. So, maybe we could do both.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Right, great.

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

Yeah, this is John Blair, are we going to talk at all...is this going to be primarily technology focused or will we get into training and implementation at all? The reason I'm asking is I'm just struck by how much we're now having to deal with who now will do this, how will they do it as the technology is starting to roll out? There are new roles for different healthcare providers.

I mean, I was just in a meeting today, the capability is there and they're trying to decide who now is going to be looking at this information that's coming in on the screens and dealing with it and they're not sure where to go with this. This is a large institution.

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

I think that's a great point and at least my understanding is that we are definitely looking at a broader aspect than just technology because in the real world, you know, if you think of interoperability experience technology is only one of the factors. I think the human factors are very important and as we get into the discussion of where it is working and where it is not working we should be identifying where technology may not be the problem actually the problems are more related to workflow and settings and incentives. And so I think, at least from my perspective, that's important but I'll let others also, you know, share what their thoughts are.

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

This is Jitin; I'll echo that sentiment as well. The feedback we've heard in both the Standards and Policy Committees and from within ONC as well as that, you know...as far as official sources of feedback are concerned I think it is agreed that this is...you know these are multi-varied problems and we should not be trying to tackle just an aspect which really does not actually give you a real solution and then of course, just speaking from personal experience, just solving one particular aspect really does not mean you have actually pushed the ball very far in terms of the usability.

So, I'm all in favor of thinking about the various aspects of the solution and, you know, when we get to the point that we are describing solutions, as Anjum just mentioned a minute ago, today we'll continue focusing on needs but when we get there I definitely don't think we should be limiting ourselves.

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

Jitin with...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Hi...

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

That why don't you just move into the use cases and we can continue the discussion I think related to some of the use cases as well as the framework.

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

Yes, sure, it sounds good, although was somebody about to say something?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Jitin, this is Cris Ross, I joined late, but I'm on the call, thank you.

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

Oh, terrific.

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

Welcome, Cris.

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

Welcome, Cris. All right, terrific, so I just wanted to...we are going to try something at least that I've never tried before which is I'm going to run the rest of the webinar off of my computer so I can capture some feedback and the discussion in real-time. Is everybody seeing my screen? You should be seeing use cases and identifying needs on your screen?

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

Yes.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

I am.

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

All right, terrific.

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

We see it, yeah.

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

All right, fantastic. All right, so as Anjum mentioned in the opening remarks today we really want to spend the time on needs. Needs is tricky because obviously we are all familiar with various solutions so it's easy to go to solution-making quickly and sometimes you need to think about solutions a little bit to be able to identify what are the needs that you need. So, we will...you know there will be a little bit of a balancing act but we're going to try to stick as closely as we possibly can to needs.

Before I jump in the one thing I will add in addition is that we're trying this for the first time, at least Anjum and myself in terms of leading such a collaboration, if this had been well solved before we probably wouldn't have needed a Task Force, I'm sure for most of you this...there are some aspects of

this which are new so please help us to, you know, get the ideas right. This is a very willing group already we can see so that's terrific. But if there's anything you think we should do that can enable a better discussion whether you provide it here online or you provide it off line that would be super helpful to us so we can help make sure that this Task Force gets to where it needs to.

And without further ado let's jump into...well, let's just talk about the framework that we outlined last week and really what...you know the guidance we were given that Arien and Paul also underscored last week was that we really want to identify those three to five top most important interoperability needs and identify whether or not they're being achieved, whether they're being partly achieved, whether they are fully achieved out there and have, you know, more or less been solved. And today we're going to spend some time thinking about those.

As you can see from the marked table at the bottom, you know, we'll...as we identify needs related to use cases we'll describe, you know, where, you know, how well they're achieved and, you know, certainly in more detail than is on this marked table as well as how important is it that we'll...you know, as we run through we'll figure out if everything is high maybe that's a less useful column, but if there are needs which are clearly more important than others than it will be good to surface out that detail as well and then we can, you know, further think about refining the content we generate today, you know, off line and in the next meeting.

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

This is...

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

So, this is the rough framework, sorry, somebody was going to add something?

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

This is Janet; I did have a question about the needs being fulfilled or need being fulfilled column. I'm pretty sure that, you know, throughout these we'll identify things where one group will say "well, yeah, that's totally working in my area" and a lot of other people are like "wait, what?" You know...

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

Yeah.

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

Is there some way of like sort of like met sporadically or met in places, is there something like that? Because there's both the quality of how it's met and then how widespread that is and I think those are two different axes.

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

I...this is Jitin, I absolutely agree. I think that number two bucket is meant to be that sort of catchall but I do think that those are places where we might actually want to articulate the circumstances in which it's being met. It might be the case that there are specific groups who are solving it and it actually maybe worthwhile to dive deeper into those groups or to bring their knowledge to bear.

It might just mean specific circumstances where something is being addressed but in others it's not. So, absolutely, unearthing that level of detail would be more valuable than just, you know, saying it's met or not. So, hopefully that resonates with how you are thinking about it Janet.

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

Yeah, that makes sense.

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

Okay, terrific. So, the approach we took, as we started describing last week and we're going to jump in a little bit more this week, was, while it's very hard to describe interoperability experience needs just in a vacuum what makes it more concrete and an ability for us to thoughtfully discuss it is to discuss them in the context of some use cases.

So, at the end of the last meeting we essentially asked everybody as sort of homework if you have ideas for use cases which makes sense please share them with us. We got a few responses. I know some others might have...you know we might want to discuss a couple today.

So, we came up with these five here that are on the screen. These are not meant to be collectively exhaustive. There may be a little bit of overlap but our hope is that if we are able to cover and identify needs in, you know, these use cases then we would have identified the...you know accomplished the 80/20 rule.

It sounds like from our earlier discussions there may be a couple of others we right off the bat want to add here because they are really not served but let's go over these five first and then see if that's the case.

The first one push/pull from the PCP to specialist, actually we received this one from...we received this one from ONC and it is really important because as we went through our use cases it was clear that we had a clear gap where the PCP and specialist interaction was already called out in Meaningful Use Stage 2 and there are probably huge gaps there that if we help solve they are going to be important just for that use case alone as well as flow into the other use cases. So, that was the first use case.

The second one was a more pull-based use case between the PCP and specialist to interchange...well, I think we called it specialty but I think it's PCP and ER, to interchange, oops, I think we have a typo here, it's to exchange data between the PCP and ER through pull-based exchange particularly in an environment where getting things like patient consent might have its own set of restrictions across state lines for example. So, I apologize the description here is a little short. I think we copy pasted the wrong description here. But that was the intent to be able to look, you know, across state lines consent how do you obtain consent especially in a situation where you have a patient who appears in an ER in a state other than the one they live in.

The third transition of use case, a more straightforward one, but one that's still not fully solved which is the push use case from a hospital to a PCP or from a hospital to a post-acute care setting with appropriate notice to the PCP, which is probably the more interesting flavor of it.

Then the fourth one is shared care plans not something that was necessarily called out for Meaningful Use Stage 2 at least, but enabling automated push of oncologist's visit or care plan along with an order for the home health nurse sharing care for the patient and enabling all participants to get information from that feedback loop in order to continue managing care of that patient across the continuum.

And the fifth one, which was very...you know the patient is certainly included as sort of tangentially in those first four but in the fifth one it really was focused on the patient themselves and their opportunity

to participate and by patient here we really thought about patient/caregiver of the patient since it's not necessarily the patient themselves. So, I'll just read that out here.

The diabetic patient's caregiver gathers notes and lab results from her PCP and her endocrinologist may do something clever like graphing them or adding data to them and submitting the patient's, you know, personal device readings back to both the doctors, you know, from whom he or she is receiving care.

So, those are the five use cases that we gathered off line which seemed to have fairly good coverage of the variety of topics that we want to address as we look at the interoperability experience. What does the group think of these five and which ones would you add, modify, eliminate based on, you know, based on, you know, your view-point and experiences?

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

Hey, so...

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

Hi, this is...

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

Go ahead there.

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

Shaun Grannis here, I think these are good specific examples of potential workflows that can be supported by a variety of systems. I'm trying to think of what is maybe more information exchange specific and I might be...my scope or context might be off a little bit here, but I would think of another use case which is a bit broader in scope and maybe it's too broad, but information exchanges today function in a variety of ways but fundamentally what they do is they convey information from one entity to another. Few information exchanges today actually do that and are standards-based and fully syntactically interoperable.

So, I would think one of the visions here for exchange is to have seamlessly interoperable exchange of information from one entity to another and while that's large and generic I would just submit that often we exchange documents that are viewed in another system besides our primary software and so I think one of the areas where I think we need to start doing significant work is actually saying the information exchange should be playing that role of delivering from one system, an Epic to a Cerner, and do that seamlessly not just in a document or a non-interoperable way.

Information exchanges have a lot of aggregate data. That aggregate data needs to be delivered into clinical workflow and I think that larger vision actually supports just about all of these use cases. Does that make sense what I'm saying? Is it too broad?

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

Anybody feel free to weigh in by the way. I'll weigh in and again this is Jitin. My view-point on that is...the way I piece together that or maybe tease apart that use case Shaun is there is an important player there which I don't think the current use cases cover called the information exchange and that is worth calling out as they are a part of our...an important part of our exchange landscape.

I've always found that information exchange as it is, is not a...it's not a user centric view of the world and what a doctor is trying to accomplish, which presumably nobody is just trying to accomplish information exchange, but rather some sort of care for the patient. So, I think that it's valid to bring information exchange. I think it is probably valid that we talk about the ability to do so in a software program that's not necessarily the primary EHR of the provider, but it probably still fits in from a clinical perspective into some...I think there should be still some clinical use case that calls those out as actors or constraints rather than information exchanges themselves being a use case. That's one perspective. Anybody else?

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

Yes, this is Jane Perlmutter, I'm sorry I was disconnected and I'm a patient advocate still not totally grounded in what we're trying to do. But I'm wondering whether we want to...particularly from the patient's focus there would be other important parties like the payer or a pharmacist, or a provider to find out financial information, I'm not sure if any of these are things that you want to consider, but in addition to the patient engagement that you list I can imagine a lot of other things that patients might want to be doing that would include other healthcare players.

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

This is Larry, Larry Garber, I love that. I really...I think we should add a use case that talks about, you know, prior authorization and, you know, maybe showing the cost to the patient for various options. I love it.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

This is Kelly Aldrich, I agree with those comments, but I would have to say again, I would really advocate for this group not to be focused on the doctor as I've heard now a few times. It is about the patient and the patient centered information flow. So, I really appreciated, I think it was Shaun who you had said about the information exchange and then maybe the users are just consumers of that data through the continuum of care.

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

I have a comment, this is Jorge, Shaun this is I guess I want to make a comment based on what you were...the example you were giving. As an exemplar do you mean for example let's say that you have a patient that is seen in a, you know, ambulatory type clinic and he is referred for surgery and then he arrives to the operating room night for an acute appendicitis and needs to be operated on. Are you talking about health information exchange for example the ability for that entity, Clinic A, in wherever, to be able to send the preoperative historical workup of that individual to the operating institution that's going to be in receipt and is going to be doing the actual procedure? Is that the kind of exchange that you're talking about?

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

Yes and making that data actionable so that...

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

Correct.

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

If the clinic sends a medication allergy the receiving system can actionably respond to that and send an alert to say the anesthesiologist as he's beginning his process.

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

Okay.

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

So, you're generating a list or a report.

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

Correct, so you think that by pushing not just the clinical viewable content of the assessments that were done prior to the next entity having to provide the care but also you're interested in the logic sort of so there's not duplication of tests, studies and preoperative management. Is that what I'm getting from you?

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

Yes.

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

Okay.

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

Again, I think those are all examples of potentially actionable pieces of information and right now we're expecting a human being to sort of review a list or a report and make decisions, and we need to start exchanging this data and feeding it into each other's systems in an actionable way.

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

Okay, because that exemplar shows, and this is again not a clinician centric, but a patient centric but that individual is ultimately going to be put into harm's way if this information is not transferred timely, accurately and appropriately.

So, it's...I know we're sort of having that artificial divide between patient centric and clinician centric, every clinician on this phone call is patient centric. So, we shouldn't just arbitrarily try to make those the same from the beginning.

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

This is Janet, I have maybe more of a structural question about these use cases. One of the things that I'm finding really challenging is trying to figure out if and how we want to kind of presuppose infrastructure in this case. So, for example, I could look at these scenarios and say, well, if all of these providers use, you know, work from the same healthcare delivery organization and use the same EHR then hey all of these work today this is easy.

Similarly, I'm sure Jitin looking at this you think that if all these people and these players were members of the same exchange network, like CommonWell or eHealth Exchange or things like that, that again, yeah, this seems like a pretty straightforward kind of thing a lot of people do that. So, in one sense it makes sense that we should have kind of some limitations infrastructurally on this so that it actually is meaningful.

On the other hand, I'm kind of struggling with the opposite direction where, you know, Shaun was pointing out the need for a health information exchange in some of these pictures and I was thinking, well, you know, like an Epic and Cerner system would just exchange the data point-to-point we could do that too, and so in that case it was presupposing an infrastructure that maybe wasn't entirely necessary.

So, I'm just kind of curious where you see sort of drawing the line on that and if anyone else is kind of struck by that challenge?

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

Good question, I agree and I've been thinking about that too, Shaun.

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

So, it's Larry Wolf, I want to jump in on that. I think that's actually a great example of it might be worth thinking about a column that speaks to that specifically that says, you know, if you have this infrastructure this is an easy thing, if you don't have this infrastructure it's a medium thing or it's a hard thing, because I think it begins to highlight what infrastructure is in fact helpful and that there may be multiple good options for connecting things it doesn't all have to be single vendor platform, they might be, you could be in a, you know, highly functioning regional health information organization, you could be using some national backbone infrastructure. So, I think those would be good things to explore.

Also, want to jump back to some of our use case discussion. So, I'll pick a corner case which I think is obviously getting a lot of attention outside of the direct care area which is the whole area of care management and that visit or encounter notification I think is a really valuable thing and I'm seeing lots of examples of that happening out in the field and it's not pushing a summary it's just the fact that somebody was at a location getting care and the triggers could be anything from an admit or discharge message or an insurance verification message there could be a lot of things that actually trigger the high likelihood that a patient is getting services somewhere and that it can result in really good effective interventions even I have some examples of where the information doesn't happen real-time but happens next day.

So, I think maybe we should look at some other use cases that are important to health and care beyond these specific ones.

I also think that there is a continuing tough nut that it feels like we should be really close to being able to solve around comprehensive medication management to...it's like a subset of the shared care plan, it's what are the medications this patient is on, why are they on them and as their needs change, as the plans change how does a list of medications get updated, how do we have good communication with pharmacies, how do we have good communication with the individuals so they know what they're taking. There are various technical options for creating home tools to use at home to better manage your medications which may or may not get automated feeds. So, it seems like the area of medication management broadly thought of could be really good.

And another one is around advance care planning. So, again, a subset perhaps of shared care plan is what am I doing around whether it's end-of-life decisions or levels of interventions, things that might show up in a POLST, things that might be more my handwritten note about the things I really value in life that I want to make sure my caregivers know about and my healthcare providers know about.

So, I offer those as some other examples of things that we haven't already touched on.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Excellent points. I've actually...

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

This is George, a lot of content to comment on, but two things I think I'd follow up with on the use cases, somewhat related to what Janet had to say about presumption of infrastructure, I would broaden the statements on the use cases, I love the way number four is worded, shared care plans, so if we worded numbers one, two and three more as, you know, transition of care, PCP to specialist, ER to PCP and de-emphasized the push/pull/push maybe those are environmental or infrastructure needs and those fall out of the needs analysis.

And then I think that the comments about actionable and interoperable data also would quite rightly fit in the needs analysis as well as prior authorization concepts. It seemed like those might end up being rows of needs that would be balanced against the priorities of the other needs for the use cases.

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

Okay, so this is Jitin, let me take a stab at this point in trying to summarize pieces of this and please correct me if I've either missed it entirely or mischaracterized some of the suggestions. So, I think I heard at least two brand new use cases and maybe a couple of flavors of other use cases that are worth calling out.

The one that I heard and I'm going to try to add it here in real-time so you guys can let me know if I've got it more or less right or not. I heard one certainly around...about actionable information back to the...well, actionable information, I'm not sure if that's...I think that was more provider centric than it was patient centric, but, I mean, I think it was Jorge's point, both are usually true in the same case as providers said themselves they are patient centric.

And then there was another one around prior auth, and there is probably a bucket of things which are related there from the patient's point-of-view, which is not met by the use cases above.

There is also an aspect of this which is around who are the players and information exchanges being a player and to Janet's point one of several kinds of infrastructure possibilities in between that can help to help describe and bring out the depth in these solutions as opposed to the problem itself that we're trying to solve.

And I'm not any sort of an expert at all on care plans but it sounds like there are probably a couple of flavors within care plans that we'd want to describe here. Comprehensive, what is it, comprehensive medication management and advanced care planning as sub-bullets. Did I get that more or less right? What have I completely left out or mischaracterized?

I'm playing a dangerous game here by trying to do this in real-time so we have an opportunity to react. So, help me out here.

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

One of the things that I mentioned that may be irrelevant but just was not commented on was exchange of information between patients, providers and pharmacists.

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

Ah, yes, yes. So, let me ask you this question, I think that's very relevant. For what clinical purpose? Was that under the authorization discussion or was that separate?

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

Well, it was the type of thing that a patient would be interested in making sure that there was that kind of communication and that the patient was notified when their medications were available, when they needed renewal and things of that sort.

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

And that...this is Janet, that also made me think of perhaps, I don't know if we want to throw like a PDMP type workflow in there looking at the drug seeker or prescription monitoring workflow scenario.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

I think all those can come under the comprehensive medication management it would just be which lens are you looking through for the flow of data.

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

Yeah, I agree.

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

I think that makes great sense I just have not been clear on who all of the players are. Here it's clear that there are providers and hospitals, and patients but it's not clear that there are insurance companies or pharmacists involved, but maybe that's just my missing it.

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

How do we bring the payers in? I'm pretty sure that you're not missing it, it's just a lot...a few different things here at once and I'm just trying to capture it all. This one certainly discussed payers...I'm looking through the notes that I just took as we walked through, as we talked through it, pharmacists, providers around...

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

I would say that it's a care team and the payers. So, it would be inclusive of all of those providing those cares and then you could say things like, you know, inpatient, outpatient, pharmacist, so looking at the patient.

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

Yeah, this is Larry Garber, I can envision a scenario where we talk about the patient and PCP having a discussion about how to treat their low back pain, you know, discussing, you know, what the cost is to

the patient or to the financially at risk PCP of, you know, a generic versus a brand name medication, you know, what are the co-pays, what are the payer requirements for getting an MRI and where can the patient get the, you know, highest value MRI, you know, which places have high quality, low cost and then how to actually get a prior authorization for the MRI, you know, or the brand name medication, and I think those kinds of things would incorporate a lot of those discussions, you know, and players, and would make my life wonderful as a PCP.

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

...

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

So, this is Shaun, I like all of the detail that we're coming up with here. I still am just trying to exercise kind of the boundaries of our exercise here. There are...every clinical interaction in the healthcare system involves sharing of data so we could come up with nearly an infinite number of these use cases. I'm wondering if we're thinking about a rubric beyond...you know there are patterns in this place.

I don't know, if, you know, you look at the most expensive healthcare transactions and if we had better information for that we could reduce cost. We could look at disease burden and go through those set of use cases and that would reduce disease burden. We could look politically and say "gosh, we all need good electronic red reporting to prevent the next Flint Michigan from happening." That would be a good use case too. I just don't know what rubric we're using because the search space here is potentially infinite, right?

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

Yeah, that's absolutely right. Actually and thanks Shaun for articulating it that way that's sort of what I was trying to route through my mind when un-humanized...this is Jitin speaking by the way for the ONC's team capture purposes.

When Anjum and I were discussing this we were trying to figure out how do we articulate those set of use cases that cover probably, you know, the...not necessarily the majority of the world but certainly some of the top priorities right now particularly as in line with the ONC roadmap, the federal roadmap and sort of the topics being discussed in the HIT Standards and Policy Committees.

Let me actually take a moment to ask both the ONC teams and Anjum if they have any suggestions around how we can...how we can tighten it so that we don't go too far astray in having too many different use cases here. There are probably a few different ways we can do this that's the good news. I just want to see if there was any guidance that we should go back to from the charter of this Task Force that can guide us.

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

Yeah, I'll go first, this is Anjum, I think the discussion is really helpful and one of the challenges we had even thinking about the strategy of using use cases was that, you know, they cannot be exhaustive in the sense that there are so many use cases in healthcare depending on who you ask and what your setting is.

And then a lot of it is also, I think, dependent on what systems are in place, so as has been discussed I think the interoperability question looks very different depending on which region of the country you are in or which system you are working in. And also it looks very different from patients and providers perspectives.

And I think a trade-off between those two worlds to really think of maybe a few use cases that encompass at least the most common interoperability experiences for providers and patients, and those kinds of stakeholders that we had, at least from our charter, been identified as the key stakeholders that we should be thinking about.

So, I like the idea of maybe thinking of the transition of care as a bucket and then see what are some of the key needs within that which are being fulfilled and not being fulfilled so that we can drill down into something.

And I think the care plan thing, which is very interesting because it probably can encompass other sub use cases in it like the medication management piece which in itself is very complex but at least if we think of a shared care plan and say how it is combining all these different pieces and putting them together in terms of planning, in terms of management I think it seems like that maybe more doable in the sense that we can maybe identify it in two or three major buckets or four or five major buckets and then think of what are, you know, some use cases within that which identify some common needs.

One other thing which I found very interesting, which has been on my mind but I haven't really understood, a lever which is this broader concept that, you know, some folks have identified which is not only thinking of...if you think around the patient and think of a more person centered approach then it is not just data coming out of, you know, medical systems that are important it is also data from other places that...and that's another whole interoperability, I think, discussion to be had in terms of when the data is coming outside the healthcare system into the healthcare system at least there is a bi-directional exchange there which makes it even more complex.

So, at some point I think we'll have to draw some circle in saying "this is the field in which we want to at least identify a few use case buckets" and then start really drilling down into that which maybe address some of the needs, because I think the infrastructure piece is more on the solution side which is that if you have an information exchange then you are addressing several of these use cases simultaneously and then what is needed to improve that experience versus if you are, you know, in two major systems that have EMR systems that interoperate quite well then you're challenges are very different from, in many communities what is being faced, which is that there are 10 different EMR systems and people have to talk through them and they are not always Epic and Cerner. So, those are my thoughts on this.

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

Anjum...

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

Hi, everyone this is Stacy I had a point to add as well and I would agree with both of you on that thought.

One of the items that we had discussed as well was really looking at it from a very basic level first, PCP to specialist I think was what we had discussed, because it is the most basic of interchanges and then

building upon it from there because there is so much that happens in between the exchange between a provider and the specialist, and everybody else building upon medication management, patient portal, authorization, pharmacy, payers there is so much interoperability that happens with all of those other communicators whether it's via Epic systems, via, you know, different systems, looking at bi-directionality.

But I think that, you know, to your point I think it's a great idea to start at a really basic level and then build upon there and determine where those impediments lie, especially from a very basic level in those first exchanges and I think from there a lot of conversation will build upon determining whether it's role-based, whether it's based upon outcomes, which I thought was a great idea as well, looking at patient outcomes.

But I think really looking at it from starting at that point and moving on was a great idea and something that I think we believe in as well.

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

Okay, so, all right, so this is Jitin, so actually I have an idea to get us a little further down the road. It sounds like, from both Anjum and several people who have mentioned so far, that the transition of care use case at the top we can probably lump them into one general use case.

To Stacy's point, as we tackle the use case and kind of tease out what are the needs of the use case we may still want to narrow cause to go to something that's, you know, concrete and specific like a PCP to specialist transition of care just so that we can pull out a lot of those needs which will largely be common to all of the transition of care use cases.

So, my question for everybody is should we go ahead and lump numbers one, two and three into one use case? Because the push/pull dichotomy may not actually be that valuable in the context of the rest of this discussion.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

That seems like a horrible way to go.

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

This is Larry Garber, I think to some degree that's reasonable. I think one of the key things is that you don't want to lose some of the aspects of these like in the ER we were talking about some of the consent issues...

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Right.

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

That are involved, you know, convey and consent, and asserting that it's been obtained. So, I think as long as you don't lose some of those, you know, functional aspects I think you could do that.

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

Okay, all right. So, let's see, let's try to capture some of that in one shot just so we have it all. Anybody else comments or concerns about just going with that approach as a starting point just to narrow down a little bit what we have?

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

Yes, it's Larry Wolf, I like this approach of collapsing the transitions of care into one big bucket. When you were first presenting that you referenced Meaningful Use Stage 2 and you sort of hit a sensitive spot I think for a lot of people of...there was a lot in Stage 2 around use of Direct that I know has gotten a fair amount of initial push back, initial problems but then my sense of it actually sort of the infrastructures we have in place.

And I'm wondering if this is a place where we could be learning from the field and maybe this is more ONC needs to actually go fund some serious field research but maybe we could help with a hearing or something on where there are successes in using Direct and I don't mean technical successes I mean actual patient care, patient coordination successes where people were happy with the information they got and the timeliness of it and it was useful for making better decisions and all of that.

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

That is...this is Jitin, that's terrific. I think...so we will...I know we've not gone into work plan yet but part of the work plan is to determine what sort of things we would like to hear about at some virtual hearings because we clearly...even though this is a very talented team on the Task Force there is still a lot more out there in the world that we want to bring to bear as we think through the needs, the solutions and our recommendations back to ONC.

So, I've captured that off line here as a note of thinking about folks who have actually had some success in creating Direct exchange based, you know, clinical care with, you know, either real outcomes or real satisfaction or whatever as a metric of what, you know, providers and patients actually care about as opposed to the underlying exchange. I think it's very valuable if we can get some feedback and some insight from the larger community about that. And I think there are some folks here on this call who can also share that as well when we deep dive into that specifically, but noted as something we want to get more information on.

Let me ask this question, if we...let's say these use cases came down to a set of themes which we are comfortable with I think we're all fairly comfortable with the notion of transition of care, there are certainly a lot of detail that you can unpack there but it's not...it is a natural clinical phenomenon whether or not there's exchange to back it up. This concept of shared care plans, again, a lot we can do here in terms of the various flavors and various levels of severity, etcetera, but, you know, again, well understood.

Patient engagement, we used a very specific use case here as you can see from the description of number three, maybe there is something more we can do to generalize the use case of what it is we're talking about.

We just added number four, five and six. Five to me seems fairly straightforward in terms of what we are talking about.

Four I am still, at least I am still fuzzy on as to what is the...what is the clinical scenario we'd like to outline? I agree that it is important and it's probably separate but I'm not sure what's the right way to articulate what it is that a provider or patient would be looking for here that is not, you know, a sub-set of one of the others above. Does anybody want to take a stab at that? Shaun either yourself as you first posited it or somebody else who built on it?

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

It's George, I'll go back and pitch that this is likely to be a need. It would be assessed as to its priority inside any of the other use cases.

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

Okay. I don't know if...okay, that's...all right that's great, that's one point-of-view and that's sort of what...

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

Could someone provide a concrete example of what they mean by that?

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

Yeah.

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

Well, let me give it a try, this is John Blair, I didn't mention this one, but I'm just thinking just about a meeting today. I think that this was brought up in the context of not just interoperability but also that the information that is received is actionable and I'm thinking about the conversation today about receiving information on admission to the hospital and the emergency room needing a reconciled medication list versus what comes in today or what may be used to come in. So, maybe that type of thing is what was meant by this.

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

Hi, this is Shaun, I had my mute button on so I was talking using my mute button, sorry. What I mean by actionable information and I think that word can have different meanings. So, I think information can be actionable in the sense that a human can consume it and take steps as a result of that information.

I'm thinking more specifically...I think we are sharing information, we are interoperating today in a way that allows us to convey some form of information, but I think the next step is to make sure that this information can be actionable not only by the human being but by the system itself.

So, I use the example, somebody, I can't recall who it was who brought up the example of the operating room, and my response was to say, well we could imagine that a clinic sends a drug allergy, today we're exchanging drug allergies often they're not interoperable, often that drug allergy might come across in a CCD and systems have viewers of CCDs but they don't take that allergy and actually feed it into the system's vocabulary so that system could say then next time the doctor tries to prescribe penicillin don't do that because the other system just told us they're allergic to penicillin.

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

A lot of systems...

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

Now that is...

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

Actually do that, I mean, like we do that electronically. George can tell you that.

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

So, I can tell you that between Epic and Cerner, so we have in our multi-vendor information exchange that does not happen. Clearly between, you know, if you are within Cerner's HIE or within Epic's HIE it works because they're the same system but the reality is we have a heterogeneous system today and among...if we're talking about large integrated delivery systems absolutely that's the case, but healthcare is delivered...we know within our information exchange that patients, ACO patients and hospital cohorts travel outside of their systems all the time.

So, what I'm suggesting is absolutely there are inroads being made to this today but largely we are exchanging non-system inter-actionable data today.

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

So...

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

Well, I guess the point I was trying to make is that even...there is actually an issue between Epic and Cerner around this one it's an interpretation of the standards but between other vendors this is done today. But we need to do more work on that at this point.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

I would say there's a...

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

This is Michelle, if I could just ask if we could try not to call out particular vendors that would be appreciated. Thank you.

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

Yeah.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Agreed.

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

Michelle, thanks for jumping in there.

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

This is Phil...

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

Sorry, let me just suggest something, Phil, I'm sorry, I'll give you the floor just back in a moment. I think I heard a couple of things, I heard first of all this is a real need, there is a possibility that it's actually being met some places and not met other places but it sounds like it's a need and Shaun I'll turn back to you as the one who posited this, that I think it's a need that really can fit into maybe multiple buckets above. So, we should talk about it when we get to needs, hopefully very shortly, and then try to unearth kind of dig out, you know, tease out what it is that is required for this to actually be addressed as opposed to it being a use case, a clinical use case in itself. So, I'm going to propose I just move it out of here, call it out as a separate need something like this and...

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

Okay.

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

And I will not lose it because it is certainly...I certainly hear of it...oops, sorry, apparently that's not a shortcut that works on this computer, okay, so I'm just going to keep it here. Sorry, Phil, I didn't mean to get in your way as you were speaking, please?

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

Oh, not that's fine. One thing I'd like to point out since we're talking about the sharing of data is there should be some way of having the patient check to see whether the data is accurate.

I have had multiple experiences with my primary care and my specialty care who are dealing with new systems of entering the data and then when I get access to it I find out they've got the wrong information. They had me listed with several disorders that I don't have. They have me taking drugs that I don't take. And then when I get back to them and tell them to fix it they say "well, there's a problem with the system and they haven't gotten to fix it yet."

So, I really think it's critical, particularly when you're talking about things like allergies and sensitivities, and diagnoses that the information that's being shared is correct.

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

Right, okay, that's and...

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

So, this is Ty Faulkner again, I think that governance should flow through each of these use cases and I want to go back to something someone else said regarding external data or I would call it sort of non-meaningful use data that needs to be interoperable as well looking at things like social determinant data, personal lifestyle data and even health index data as a separate use case.

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

Okay, good. If I can bother you to repeat that, that would be helpful to me, I'm sorry, I did not...

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

Ah, you only get one shot me, no, just kidding. So, the use case would be external data non-meaningful use data so i.e., social determinants, personal determinants, health index data, 80% as you all know, most of what we're collecting on the medical plan is not the key factor in success it's the other stuff. So,

if we can bring that in as a separate use case. And then just put governance as a flow through all of these use cases.

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

Yeah, so, actually what...governance is a fabulous term because it means so many things to so many people. Why don't you tell us a little bit more about what you mean in terms of governance and how it flows through? Totally agree from a...

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

Yeah, so one area really is DQ, just data quality. As we look through these use cases of interoperability we have to really nail down some key things, I think consent was mentioned earlier, and data quality as a component of data governance.

In fact there are many ways to normalize data so we can make some great recommendations for example master patient index is one way to just take each...each of the demographic data components have to be standardized, normalized, parsed, blah, blah, blah, but adding into each of these use cases the aspect that we also don't want to overlook for example incorrect records like what was mentioned. So, data governance in that way.

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

Okay, so I have a suggestion at this point, hopefully, I captured...I didn't capture that, you know, in horrible detail, but I have captured it here. I think it feels like a number of these pieces, external data, data governance, actionable information are all...are parts of capturing the needs for any particular use case.

My suggestion is, if we are comfortable with this as a first set of use cases and there is absolutely nothing that says we can't expand them later on or expand them off line because somebody came up with a great idea off line, we will take great ideas to the very, very end and probably beyond.

So, why don't we just pick one of these use cases and start doing a little bit of deep dive in the next 10-15 minutes as to what these needs look like. I think we've already started that exercise to be quite frank, but it would be great if we could make it a little bit more concrete around say transitions of care or shared care plans or patient engagement whichever one the group feels passionate about discussing today knowing that we'll get to the other ones as well...

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

Can I ask a very quick question before you do that?

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

Please?

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

This is Jorge, on the external data as a recipient of the data the provenance of the clinical accuracy will determine whether actually somebody will redo or not do a test. Is that kind of external data that you're talking about here or are you talking about patient generated external data?

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

I'll punt that one back to, was it Ty who was speaking about it? I understood that to mean not patient generated data but data that's not the data that is generally collected and that Meaningful Use itself was concerned about specifically.

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

Yeah, but is that data that has been collected as in the provision of care by somebody who is legally attesting to the data is my question?

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

That's a good question, I'm happy to turn that back over to the group or leave it for further discussion when we get to it.

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

Yeah, I thought it was, this is Anjum, I thought it was described as a much broader, you know, capture of data from different sources, because they were talking about social determinants of health and other determinants which will come from different sources and not necessarily from the healthcare system.

But, Jitin, generally I like this, I think I like the progress we have made on this and I also like the fact that we have identified certain common needs that, you know, already should be part of each use case discussion as we talk about them.

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

All right, so, then, I suggest let's just jump into one of these...if the group doesn't volunteer one I would just start with number one and just go down from there using transitions of care as an opportunity to talk through one. So, going once, twice, thrice if there's another one that we'd like all of us to start with, hopefully incorporating some of these needs as key needs for that particular use case and going from there? Going once, twice...

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Sounds good.

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

All right, okay, let's do that. All right, I...we have a framework on the last page but given that we just made...sorry, on the next page we had some frameworks which we were going to use as you can see from my screen there are some slides that we were going to go through, but given that we just made changes to the use cases trying to retrofit those slides maybe a little too ambitious.

So, why don't we just start de novo here, whoa, that's a very large default size for a font, and just identify some needs. So, transitions of care, let's just identify what some of the key needs are. I'm not promising this is an easy exercise but that's what we're trying to do.

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

So if there is...this is Larry Garber, I'll start off. So, if there is a physician who needs to acquire information they need to find and understand where the sources of information are, they or their EHR needs to find out the sources of information, then they need to be able to identify how to actually

access that information. Then they need to identify what consent requirements exist in order to obtain that information...

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

So, this is Kelly Aldrich, may I interrupt, I really am concerned about us taking this from a role-based perspective.

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

Kelly, what do you suggest in the case of transition of care, how do you suggest we...how do you suggest we tackle this so that we get to something that's, you know, useful, you know, a recommendation...

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Yeah, right.

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

At the end that can help us?

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Yeah.

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

What do you suggest?

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

I guess in working with so many different health systems and representing that sort of perspective and being you know...working in hospital operations for so many years I would hope that we would take this from a continuum of care and this would just be one episode that would be based around the patient.

And so if the patient presents through the different transitions of care then the patient needing to share things such as the medications and history and so forth it would be the consumers of data that would almost pop in to be able to take out that reliable secure information.

So, it's almost like an arrow, if you would, and that arrow represents the patient's longitudinal continuum of care and maybe these dips in data needs are then identified off of that line. Does that make sense?

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

Well, this is Larry...

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

So it's not about the role.

**M**

It does.

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

Go ahead?

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

No, I just...

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

I almost imagine...it's Larry Wolf, I almost imagine that you're saying, I show up for an appointment and instead of being handed a clipboard or a tablet that's essentially blank I'm actually able to bring my information with me and there is some way that it gets brought into the provider's system and then some way that I can review the net of what's there.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Right, that's...

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

Is that the kind of thing you're talking about?

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

It does, that seems interoperable to me not only on an infrastructure but conversational and semantic and all of those attributes that we would think about with interoperability that it's about...it's more about me being the data holder as the patient and as I go in these transitions of care then people are able to reach in to that unique source that should hold all of the data and share that information out.

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

See, but this is Larry Garber, so, I understand what you're saying but you're actually presuming a solution whereas in that scenario that you just described what you're trying to do is get the information to the physician who is going to be caring for you and so, you know, in what I described in the first three bullets the physician needs to acquire information, right, and where that information comes from.

The source maybe via the patient, it may be the patient is the one that says "you can get it from my PCP and my endocrinologist." But in the end your goal is actually to get the information to the physician and so I'm not presuming how that happens but that you do need to get the information to the physician, we need to understand how...and there has to be a process to get that information to the physician and there has to be...we have to do it under laws of the United States and so, you know, I think it's more general to do those first three bullets than to presume that we have a solution where the patient is the provider of all the information.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Well, we're an Interoperability Experience Task Force this is not the Physician Experience Task Force, this about the care team and the patient centered data flow.

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

So, let's take one step back.

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

Well...

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

I actually think we're actually talking about almost the same thing here. So, interoperability experience goes back to a lot of participants on the network the patient is a key participant, so is the provider, so are others, social workers, others might also be part of the experience.

I think all we're saying here is that there is the first perspective that we went down, the first three bullets on this page, really centered around what is the physician experiencing or at least the way they are worded suggest it's what the physician is experiencing and the next two, which I'm sorry are not complete because I'm just trying to capture it but I didn't quite do a great job there, but they are in the direction of a patient centered view of what that experience is and maybe there is a sort of third-party view that says, here is functionally what needs to happen, the provider must be able to get the data in order to take care of the patient, the provider must or the patient's consent must be available to the provider and that is hopefully less suggestive of a solution which could be provider centric or it could be patient centric, or it could be system centric, maybe it could be something else entirely...I'm spit balling a little bit here but...

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

This is...

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

It feels like there is...that you guys are actually not really talking past each other you're really just looking at the same problem with a couple of different potential solutions.

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

Yeah, I think so...

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Through a few lenses, I agree.

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

This is Anjum and I was thinking that, you know, it is about the emphasis to some extent so even if what you have written in the top, the three bullets, the physician needs to acquire information, I think if we add a bullet above that which says, the patient presents, you know, in different parts of the continuum and this is one place where they present, I think the rest will follow as the next steps. So, it will still be patient centric but I think it starts from the patient actually presenting and not the action being initiated by, you know, just the physician on their own, I think that kind of allows it then to feed that across any continuum, across any settings in that continuum. I think the steps of transitions of care would probably look fairly similar.

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

This is...

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

It's George, I think we have a patient departs also. So, to handle, you know, ER/ED, acute discharge, patient's departing probably a little different than patient shows up or presents.

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

Right, right.

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

Right and by patient centric I think it's important for us to, at least in my definition what we mean by that, is that the unit of data is about the patient but that doesn't mean that the patient is always involved in transferring the data.

I mean, as someone just mentioned the deceased case but also, you know, someone who comes into an emergency room we need interoperability to get that patient's data to the various providers even if the provider is half way across the country and has never seen the patient before.

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

Yeah and it's George again, by depart I didn't mean physically this world I'm in. I think I should have said...

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

Well, but that is another...

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

...

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

The issue.

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

That's a really bad outcome.

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

A really bad outcome.

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

But it's inevitable.

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

Let me...this is Jorge...

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

Not...

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

I just wanted to make a comment, maybe perhaps we can come to an agreement sort of any clinician, you know, whether that's a nurse practitioner, PA, dietician, you name it, any time there is a clinical encounter where you have an individual we call patient and a provider we're calling clinician then I think that's what we're talking about here not sort of a physician centric or physician heavy sort of recipient of the content. Maybe that will minimize some of the discourse we're having.

**M**

That sounds reasonable.

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

But can I add...this is Phil, I'd like to add one other thing, when you're dealing with multiple physicians or movements to other places it's important to know why the patient is there so that they're not coming in as someone that's new and has to be worked up completely and then have a battery of tests where in fact the person that referred them may only have one question to ask that needs to be answered in order to handle the case.

So, I think the data is really important but the rationale for being there is also important. In an emergency room that's not so much the case but when you're referring from primary care to specialty care I think it's important that primary care outlines what they want to learn from the specialty care otherwise the patient walks in blind, they get all this stuff and they just work them up as though it's a completely new package whereas they may only be in there to find out the answer to one specific question from the physician that's been handling the case all along.

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

That's a really good point. When we think about the information that a clinician would want and for that matter what the individual would like their clinician to have in a transition of care case it is a clinician providing the care then that cannot just be what we're limited to thinking about in terms of things like Meaningful Use which called out the clinical data elements of the chart that need to be structurally encoded, but as well as the rationale for being there, which actually in some sense can be captured there in the CCD and so on, but it's, in my mind, at least it's a distinct component from just a clinical...the clinical history for the patient. So, absolutely agree.

Why don't we try expanding this out where we started trying our best to keep it at a level that is more indicative of just the things...the jobs that need to get done for that patient to receive appropriate care, maybe I should say, the best care, and not assume that it's going to be a clinician EHR patient centered, you know, none of those, or solution centered around each of those because there may be multiple solutions that do those jobs just as well.

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

Good.

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

So, let me give it a shot and then please correct me and help me out too. So, an individual, let's say we start with the premise for now that an individual presents at a setting of care, the clinician needs to acquire information on that individual's history and, you know, as per the last discussion it could be a few different ways, but the data should be clinical data, a rationale for being there, there may be other things as well. The clinician needs to know how to...I think there is something here about the clinician

has to be able to get access to that information, has to be able to get access to the information no matter how that information will be...no matter who is driving the information the clinician needs access to the information.

And the ability to...there is something about the ability for the patient's consent to be identified and consumed by the clinician. What do we think? Is that closer to what we think are some of the key needs? Is there something better? Clearly the story is not over yet as well, how would others like to add to this story as we create it for the needs for that transition of care?

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

This is Phil again, that's great, I like that. I would also add that whatever the new physician does has to be able to be entered into the record so it can go back to the general world if they have to use it. So, in other words it's not just received but they also have to enter.

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

Contribute back to patient's record. Okay.

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

Great.

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

There are probably some steps in between here, but it's captured. What are some other steps in between here or after this?

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

It's Larry Wolf, I think the patient's record maybe we have to make this more than the record which might just be the local record, right, but back to the other members of the care team including the patient.

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

Should I use this word...

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

And some...residing in the record or multiple records that's great, but the fact it needs to get to others I think is really the operative piece here.

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

Okay, I...

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

We don't have one, we don't have a single longitudinal record.

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

Yeah, I just realized that as I wrote that word down...

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

...somewhere.

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

It might be too loaded.

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

It's a great goal, it's a great goal, it's a great goal, but I think today we have fragmented records held by multiple providers, multiple organizations, patients have their records in multiple formats, you know, stacks of paper of care summaries and piles of insurance bills or statements of benefits and, you know, we've all kinds of things. So, I think patient record in my mind speaks to me about a data repository whereas in fact we want to get it to the individuals and the organizations.

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

One of the groups that I work with, this is Phil again, deals with something called the Passport, the Patient Passport, which is individual to the patient and that is their full record that everyone within that system can contribute to including the patient and that's available. And the question would be if you're in a system like that where a "Passport" does exist and suddenly you're in Southern California in an emergency room there should be some way for those people to access that particular record and that's...

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

The...

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

That's for the fortunate few that have that sort of a system as opposed to many people that are just bouncing from emergency room to emergency room and do not have a good health plan.

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

This is Anjum, Phil that's a good solution probably because it's this issue and so Jitin I would suggest that when we talk about a clinician being able to contribute back to patient's records then probably...that's patients record is shared with the care team for that patient wherever...

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

Exactly.

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

That patient is in the continuum.

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

Exactly.

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

Right, it may, again, you know, one of the things we expected is when we start going through some of these use cases there will be aspects which are common across the use cases and, you know, the shared care record of some sort might be...that feels more, you know, more like a solution than a need but maybe it's both and, you know, reflects well on sort of at least two of the use cases we mentioned, this

transition of care use case and the one we've literally called shared care plans up here on the previous slide. So, I want to just do a time check...

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

Jitin...

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

We're at 2:26.

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

Yes.

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

And I was just about to say, Michelle is just going to call me out for the timing so there we go, we are sync, this is the beauty of Boston-based people we all think alike. Michelle, what do you suggest we do at this point given we have four minutes left? We can certainly continue this at the next discussion.

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

Yeah, I think that we need to regroup off line, but I might suggest that we might need to have some homework done for...and we can figure it out I'll talk with the Chairs, but maybe we can assign some homework and have people bring thoughts back for the next meeting just based upon how far we got today, but we can regroup and assess that, but if that's something we do decide to do the members will be hearing from us with your assignment and homework and hopefully you'll be willing to help us. But in the meantime I think we should just open up to public comment.

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

Okay.

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

All right.

#### **Public Comment**

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

Lonnie, can you open the lines?

**Lonnie Moore – Meetings Coordinator – Altarum Institute**

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

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

So, we did have a comment in the chat, a suggestion for a framework that we can use, so I will share that via e-mail with the members of the Task Force and thank you Olga for sharing that with us. And it looks like we have no public comment so thank you all for your participation today, please be on the lookout for some next steps, I think we need to do a little regrouping to adjust our work plan and we will get back with you as soon as possible.

So, for the moment our next meeting is scheduled for April 6<sup>th</sup>. We are looking to schedule another call or so. So, also be on the lookout for those and thank you all and have a wonderful rest of your day.

**Kelly Aldrich, DNP, RN-BC, CCRN-A – Chief Clinical Transformation Officer – Center for Medical Interoperability**

Thank you.

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

Thank you.

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

Thanks a lot.

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

Thank you.

**Jane Perlmutter, PhD, MBA - Founder & President – Gemini Group**

Bye.

**Public Comment Received During the Meeting**

1. Olga Strachna: I recommend using a framework for defining use cases for evaluating HIT success factors. A good framework is the FITT (Fit between Individuals, Task and Technology) framework to help analyse the socio-organisational-technical factors that influence IT adoption in a health care setting. See here <http://bmcmeginformdecismak.biomedcentral.com/articles/10.1186/1472-6947-6-3>
2. Olga Strachna: for # 4 the distinction is the timeliness of the data delivery: real time messages versus documents sent for transitions of care scenarios