



Collaboration of the Health IT Policy and Standards Committees

Interoperability Experience Task Force
Final Transcript
June 1, 2016

Presentation

Operator

Thank you, 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 Joint meeting of the Health IT Policy and Health IT Standards Committee's Interoperability Experience Task Force. This is a public call and there will be time for public comment at the end of today's call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Jitin Asnaani?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Here.

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

Hi, Jitin. Anjum Khurshid?

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

I'm here.

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

John Blair? Cris Ross? George Cole?

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

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. Kelly Aldrich is not able to attend. Larry Wolf?

Larry Wolf, MS – Principal – Strategic Health Network

I'm on, thanks.

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

Hi, Larry. Larry Garber? Phil Posner?

Philip Posner, PhD – Patient Reviewer – PCORI

Here.

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

Hi, Phil. Shaun Grannis? And Ty Faulkner? And from ONC we have Stacey. Is there anyone else from ONC on the line? Okay, with that I'm going to turn it over to you Anjum.

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

Thank you very much. Welcome everyone to this call really appreciate your finding the time to be on this call I know there a lot of things going on including the annual meeting so we appreciate your being here.

So, the agenda today is mainly to review some of the outcomes from our exercise that we did following the virtual hearing and then also really transitioning into the phase where we start finalizing some of the recommendations that will go to the Joint Committees. And I know that Jitin will probably be with us for some part of this meeting, right Jitin?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes, that's right, I'm just waiting for my flight to board at the airport unfortunately, timing didn't work out quite right.

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

Okay that's fine I appreciate your being here for at least a part of this. Next slide. So, just to recap, you know, for all of us, we are basically focusing on looking at what should be our recommendations to the Joint Committees that will help move the objective of improving interoperability experience for providers and patients.

And our task is to include policy, technical or other approaches that would help in improving that. And to that effect so far what we had done, remember we started off with really identifying use cases where that interoperability experience would be needed or could be impacted and we looked at, as you remember, we looked at transitions of care and patient generated data, and, you know, transparency, and quality measurement and those kinds of use cases.

And from those use cases we identified some priority needs, I think we had eight priority needs, which we're kind of breaking down across these different use cases the needs that will help in improving that experience and as you remember they started with identifying the patient and then being able to locate their records and identify, and access providers through provider directories and so on.

And so, then we held our virtual hearings which were very informative, we had three different panels from different aspects that informed us, so very detailed, I think some detailed conversations about some aspects of interoperability.

And then the last thing that we did was to, based on the virtual hearings and our prior discussions, we asked all of you to rate the top three that you thought would be most impactful in terms of moving forward, the needs, so that we can really starting thinking of solutions as well in our recommendations. Next slide.

So, based on the...and so thank you everyone for sending your responses to the prioritization exercise that we did, we wanted to make sure that, you know, all of you get an opportunity to contribute to that discussion and prioritization.

And so what was interesting was that obviously we had eight categories, as I mentioned, and almost each one of them got at least one vote which means that none of these things were not supposed to be there. I think somebody at least thought that one of these things was a priority which is good.

And then, not surprisingly, I think that what was fundamental to the user experience was kept as the priority. So, what came out as the top three categories, which was a fairly clear consensus I think in terms of the number of votes we received for the categories was, number one was the ability to meaningfully utilize the data which I think makes a lot of sense. Also from the other discussions we've had its impact on reducing the cognitive burden both on patients and providers, so that was a thought category.

The second was ability to exchange data both pull and push I think come under this and I'll show you more details around that.

And then ability to encode data that is syntactically and semantically interoperable. So, those came out to be the top three and I'll just give you a brief on each one of them, next slide, before we open it up for discussion on this.

So, the summary I think in terms of these top three categories was that aligning policies, business, technical and clinical workflow needs for providers and I think patients to meaningfully use data. And there is the thought need in terms of improving the interoperability experience and I think that also I would hope we would be able to include the example of aggregating data for population health and quality reporting also as part of this when we think of meaningfully using the data.

The second was more related to open APIs and being able to accept direct communication from patients and also utilizing some, at least, technologies for data validation and consent from patients and to be able to interoperate between different systems more effectively which was kind of the exchange of the data aspect.

And the third was really around a standardized data coding and automation as much as possible and we heard several, I think, experts even in our virtual hearing who at least are trying to address this issue as much as possible so they can help with developing more insight from the data and then just basically moving data from one point to another. Next slide.

So, these were some of the specific needs or some needs that we had identified, this is just a recap so that, for these at least top three priorities we wanted to at least show what were the sub-bullets within each so when we talked about meaningfully utilizing data, at least reducing the cognitive burden aspect of it, we talked about the reconciliation, data reconciliation which was highlighted several times in the virtual hearings, clinical insights that can resurface from this data for providers and patients, the usability visualization aspects of this and also usability from a workflow design aspect of this. So all these is how we understand the system which otherwise could mean many things, you know, when we think of meaningfully utilizing the data.

And similarly when you talk of the ability to exchange data some of the subcomponents that we had identified, which would be very granular related to retrieving and querying data from EHRs and pushing and pulling data and also includes device data, and data directly generated by patients. So, that again is also a fairly large bucket in that respect.

And the third category that has been prioritized by all of you relates to encoding data and that relates to encoding computable data or discrete and free text data, and then I think that one of the major things that was pointed out several times was also taking into account non-clinical data from social, behavioral aspects as well which is important for looking at overall health outcomes. And then we also touched upon the provenance of data aspects. Next slide.

And so what we tried to do was to, just based on, again, the discussions we have had and also some of the transcripts from the virtual hearing is try to at least identify some direction in which these priorities maybe moving and what we would want, I think, as part of our discussion today is really to maybe make better sense of when we think of these three priorities what comes under it and what would be then further prioritization within each bucket in terms of where action needs to be taken so that we can improve the experience.

And we have, later I think in the discussion, we have proposed at least a matrix where we can start at least capturing some of these things more systematically and then building our recommendations for the Joint Committees as we move forward in the next two or three meetings that we have before we have to come up with our recommendations.

So, under meaningfully utilizing data what we captured was a real focus on trying to automate and doing more reconciliation at the backend so that it reduces, if not totally removes, the cognitive burden on providers and those who are using that data.

It relates to being able to utilize open APIs and adopt solutions that are consistent in terms of some of the metrics for which people have incentives, because I think we had this discussion about why would people use data and I think part of the insight, that at least I captured, around some of these things was one statement that I think probably Larry Wolf made was around that by using data you also automatically start working on the backend of improving the quality of data and so the ways that data are then used in the workflow, so improving the use of data is extremely important and then the incentives and some of the other outcome-based metrics maybe some of the reasons for which the data are used more effectively. Next slide.

So, one aspect that we discussed internally, at least as we were going to present this and also recap for ourselves, is that sometimes it's helpful to actually look at specifically what people had said because it informs both us and to those who were not part of the virtual hearings and have not been part of this process to understand what experts from the industry have communicated to us.

So, for each of these top three priorities at least we have at least tried to identify some quotes from the virtual hearings that we heard were relevant to this. So, what you see on the slide, and I won't read through this, but are again, snippets that we identified were relevant to at least the message that we got.

There is obviously a lot of people who had very valuable things to say but, again, this is just a taste of what we got and trying to share that I think with the Joint Committee as well at some point and I think we will make that decision of whether this will be part of like a presentation or just part of a document that goes to the Joint Committee with our recommendations, but we were using this here also as a check on ourselves in terms of are we capturing some of the points that have been made. Next slide.

And so the second priority need was ability to exchange data and again I think there are some overlaps in terms of what is required for meaningfully using data but we touched upon, again, the role of APIs, the role of authorizations and what can be used and there are some examples from other industries as well that are using some of that technology.

The direct communication was still an important aspect of this and being able to accept direct communication. I was just talking to somebody yesterday who is a pediatrician and they were saying that one of the challenges they are facing with a lot of primary care physicians and pediatricians is that when they are trying to use Direct to send data sometimes the other party is not receiving Direct messages because they may be trying to use some other network for getting that information. So, are there challenges around that which have to be addressed in order to improve the experience around exchange of data.

And then also there is...we heard in our virtual hearings that even when there are infrastructure like a health information exchange that facilitates that exchange of data that there is a lot of variability from state-to-state which is a challenge for I think people who are working across state lines and there are also sometimes costs associated with even using that facility. Next slide.

And so these are again some quotes from our virtual hearings around open APIs or codifying auth's or around being able to receive data as well as view, download and transmit from a patient perspective. Next slide.

And so the third and last category that we have prioritized at least based on your recommendations is the ability to encode data that it is syntactically and semantically interoperable, and this relates to, you know, the data format, it relates to standards and commonly used terminologies for care coordination. There were discussions about improving standardization when data is coming from different sources not just from an EHR.

And then also I think we heard that especially from the perspective of public health of being able to standardize formatting of non-clinical data that is coming from other sources than EHRs from the community yet is extremely important as we think of health outcomes in our patients and also at a population level. Next slide.

And so these are some of the, again, quotes that we talked about in terms of, you know, reconciliation of data or being able to move discrete data and the semantic coding.

So, I will stop there and actually open this up for comments from all you in terms of where we have landed after our discussions and after our virtual hearings and if you have suggestions or reactions to the top three priority needs and how we are presenting them.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

So, this is Janet, I guess one of the things that still feels like it is kind of missing here is that a lot of these things that we've said that we need it doesn't seem like we've done like a real good root cause analysis on why we don't have them yet. So, like going back to one of those, which is like, you know, we need the ability to push data to other people or something like that.

I mean, I think that, you know, we've all said that we need that and in fact our systems are all capable of doing it and that's sort of the point, right, of this that we have the technical ability to do it and I guess the part that I feel like is missing is the part where we look at and say, well, if generally we all agree that we need to do this and we all technically, at least in EHRs, certified EHRs, have the ability to do it why isn't that happening today.

And maybe the answer is, for example, there aren't enough HISPs out there or people aren't joining HISPs and so then the next question would be, well, why aren't they joining HISPs, you know, so sort of doing like a five whys root cause analysis back to figure out what the specific recommendations are at the root cause to be able to address some of these more broader issues.

I'm curious if anybody else has that same feeling of perhaps being too broad right now to be able to have any solid recommendations out of this?

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

Yeah, this is the other Larry, I actually was looking at this and having the same feeling and I was wondering, the question I was wondering is, you know, we were...we had eight areas that we were voting on and I was just wondering if you looked at the, I don't know the histogram, of our voting was there a natural drop off at the end of three or were there actually, you know, was it more like four or five were very popular, you know, and where the fourth and fifth items may be some of the missing links.

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

Yeah, that's a good point Larry and I think there was, as far I remember and Stacey you can correct me, that there was definitely these three stood out. There was more than one vote for four and five, I think probably six, seven, eight were only one or two votes, one vote each or two votes each.

So, we could extend this to include another, you know, category, but I also recognize that, you know, the point that Janet was making that we need to, as a group, decide how detailed we want to go with each of these in terms of why this is happening and then what can be done about it in terms of recommendations.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Hi, this is Jitin, I hope the background noise is not too heavy so I'll speak quickly or at least shorten it.

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

That's fine.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Oh, good. I have a few thoughts on that, one is, you know, to other Larry's point, at least at the time that I left about 10 days ago I know that we'd gotten most of the votes and it was great we actually did get just about everybody's vote in so at least in terms of coverage we got good coverage from everybody voting in and I somehow do recall, I don't have the figures in front of me, but I do recall there was a feed drop off after the top three and again I'll defer to Stacey as well in terms of whether that's true or whether I'm mis-remembering it.

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

It was.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

But, at least at the time I left there was...oh, okay, there was.

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

Yes.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right great.

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

Yes. The top three were clearly the ones that were voted on from a priority stand-point.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, terrific and then to Janet's point, one of the...there are really two ways of looking at recommendations, one is, you know, we've figured out something that's very specific and is problematic

and so we've done the research far enough to make a recommendation on a path forward or we have...what we have done is we've identified problem areas and we are recommending that somebody else or us, you know, continue the work forward to get down to more...the more granular issues.

Because, I agree with Janet that this feels broad but given our timeline it maybe just that we are making a different type of recommendation in terms of work that needs to be done as opposed to here's a path forward and of course there's probably a spectrum there, but I certainly agree with the sentiment there that it is broad right now.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

And Jitin maybe that's something that we can sort of frame our recommendations why in terms of like, this is where we stopped basically and these are the next steps that we see, you know, the next people taking this and going forward with just to make sure that that's really clear that, you know, we can't just say this and be like "okay, I guess we have to legislate to fix Direct now" without doing that secondary deep level analysis to find out where the problem points really are.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes, agreed.

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

This is the other Larry again, is it possible, are we allowed to recommend that we stay longer as a workgroup to do some of that deeper dive?

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

Yes, it could be a recommendation. I'm sure I think the Joint Committee will have to decide on that in terms of whether they want to continue this as I think one Task Force or if our recommendations say that there are maybe two or three different things that may require different workgroups with different expertise than that could also happen.

And my thinking also I think, just Larry coming back to your point, is that I think when we do present these, even these three priorities, I do think that we should mention at least the other five so that we are not necessarily, you know, contributing like the discussions that we have had for the broader Joint Committee as well to consider because I think that...as I said I think there was at least one person on the committee who thought, you know, those other five were also important and there was more than one.

So, I think what is more...what we have to do in terms of bringing value maybe, because we have a rather short period of time when we have to come before the Joint Committee with our recommendations, is to focus on some of the priority ones but at least we can drill down on them a little more and set the stage for what type of recommendations will go out in terms of improving the experience because I think that is something that has been...in the discussions when we had talked about federal policy is to include the experience as an important aspect that has to be addressed.

Larry Wolf, MS – Principal – Strategic Health Network

Let me jump in on Jitin's...

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

Do you agree with that?

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

Can you do me a favor and go to priority number one of three?

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

What was the question?

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

Can you go to priority number one?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Like forward two slides.

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

Slide number eight.

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

So, just looking at these recommendations as an example here and number one, adopt automation and structure formatting to remove cognitive burden from providers. Clinically give me an example of that whoever wrote this. Just tell me what you mean by that clinically?

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

I think what we...what this comes from is from the discussions and others can correct me if I'm wrong that was...I think where we were talking about being able to show insight to the provider rather than just sending, you know, all the data to the providers we are able to match for instance where there is a change in the patient's record that this be shown to the providers when they get a notification around that.

And when I was looking at this my thinking was more around, you know, like the New York HIE was giving us an example of what they're able to do before it comes out and similarly the example that I think the VA med reconciliation work was pointing to.

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

Yeah, this is the other Larry, I mean, another way to look at this is, and it's interesting that ONC just recently sponsored a, I don't know, competition, to see if...for groups to come up with a better way to present Consolidated CDAs to reduce the cognitive burden and the idea might be something that is, you know, when you get a discharge summary from the hospital right now some of the hospitals are sending you every single test result that, you know, was ever done during the hospitalization which is exhaustive and really heavy on cognitive burden, whereas if the formatting was such that, you know, you were just seeing the ones that are critically abnormal prior to the ones that are significantly abnormal and maybe the ones that were abnormal at discharge as opposed to admission, or show the ones that have deltas

where they've changed, you know, those kinds of things and, you know, bringing them to the forefront makes it easier to interpret a pile of data.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

This is Jitin...

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

Your example...in your example would you expect that it is the clinical native application that the recipient clinician is using to do that or the transmitter of the content?

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

My personal opinion is that I'd expect the receiving EHR to do that.

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

Okay, because I mean then the recipient clinician already has a UI experience that he is pretty cognitively familiar with right? So, if we do it before that then you're just simply adding more cognitive load to them. Okay, fair enough.

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

Jitin, you were saying something?

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

So, it's George, I...when I see cognitive burden and reduce I kept thinking about the narrative human readability some of the same things. I view providers as being people like chess masters when they see a board they instantly understand the situation of the game and what we present to them today is a board but before we show them the board we've shaken it and all the chess pieces are in mixed mode and all lying around and scrambled and so it's a tremendous amount of cognitive effort to find the queen for example.

I think...as I was looking through this it looked to me like, I would like us to see something more in terms of recommendations that addressed not just the human readable content but the narrative itself. I think there is a lot of missed opportunity in terms of utilizing content and user experience with the narrative.

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

Do you...so remove cognitive burden do you mean the data display density that the clinician has to view or the actual navigational effort for the clinical context other than to the episode of care or both?

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

Maybe both but I was thinking more of...so when I look at...I would think that as a provider there might be a...I'd like a provider to be able to look at a display and instantly find the...

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

...

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

Allergic reactions or the list of medications, or the list of problems that...it should be so easy for them to find those lists and perhaps there's even a suggested ordering although I don't know if there is or not, but if there were more attention to the content, particularly the display of certain types of content, that might help reduce the burden or as was discussed earlier if it were displayed in the manner in which it was consistent with their current system.

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

This is the other Larry again, you know, that's an excellent point because, so for instance in the electronic health record that I use we have it set up so that you can...you have several different ways that you can sort the problem list so you can sort it by organ system, you know, neurologic, renal, orthopedic things like that or you can sort it alphabetically, or you can sort it by priority and it's up to the individual physician or user to do that and, you know, I prefer by organ system, I've noticed others prefer by alphabetical or by priority and so each...so it's actually very independent as to how our brains perceive that chess board and that was a great analogy and we each naturally are expecting a different presentation so it's not like we can prescribe how this should be done across the country rather maybe we need to prescribe some flexibility.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

This is Jitin, I'll just...I'll add onto this what I recall from several of the discussions, particularly the virtual hearing, there was a lot of discussion around or rather a lot of mention around reconciliation and auto reconciliation, and maybe it plays to both of the points both in terms of cognitive load but more than just display but actually some level of intelligence.

But to other Larry's point maybe there is something that can be done to raise the bar on what is a fair sort of a reconciliation set of rules across the industry maybe that is something worth thinking about while, you know, leaving some amount of flexibility that again it takes in account that people are different, providers are different one from the other, but certainly the word reconciliation came up several times as we went through the notes but at least I somehow remember it three weeks later as something that came up again and again.

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

So, this gets back to Janet's point that, you know, if we're saying that each user's experience is unique to the user or desire is unique to the user and so the common denominator is the electronic health record that this user is using then what we haven't really done is finish the root cause analysis, which is that in order for it to be displayed in the electronic health record maybe it gets back to the semantic interoperability so that it can be filed discretely so that the EHR can display it in its native means.

So, I think it gets back to Janet that, you know, you're right, we haven't finished analyzing the root cause of these problems in order to make good recommendations.

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

Well in terms of then...this is Anjum, in terms of then moving this forward I think as Jitin was saying, we could identify this as an issue that needs to be resolved, which is ability for user preferences to be incorporated in how they receive data and how they are able to look at that data and then there are probably steps that have to be taken in order to reach that and I'm not sure that we need to necessarily

work through all the steps that will lead to this where at least as a recommendation that seems like that could be where we could say, we know that there are further steps needed to do this there are probably different ways of being able to accomplish this but where it is done through...or how it is done through the EHR and to what extent is the intelligence being generated by the system and not by the...not left to the clinician's choices would that be like a level at which we would be comfortable in sending a recommendation or are you all suggesting that we need to probably have another level of discussion around what are the needs that will lead to the solution of this problem?

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

I have a question for the group, is it use of preferences or it is use of task?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I would say maybe it's both I don't know that we want to get specific on sort of the...too much on the what pieces go into it.

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

Yeah, but also you need distinctions clinically as, you know, the folks who are clinicians on this call we have to...we're task oriented we have to document, we have to view data, we have to display the data.

So, whether I choose a different way than my other clinician folks on this call to view it, okay, some data prior to surgery it's going to be relevant to how I want to process the content and how much information I need in that instance, right?

So, there is, you know, obviously a user preference with regard to how much work you're requiring me to do to look for the information that I need before a case, but those are two very different things.

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

This is that other Larry, I think it is both.

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

I mean, I do too but, you know, this is something...if we don't agree on just that principle then it's pretty hard to move these things forward.

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

Yeah, so if it is both we can still like describe that as an important piece that will improve the interoperability experience of providers, right?

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

I mean, most providers don't...interoperability is a completely black hole they have no idea what you're talking about, you know, do they have the information that they need in front of them to make clinical reasoned judgments about the patient that they're taking care of. If that's what you mean by interoperability.

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

Yeah I would think that's what meaningfully utilizing the data would mean. So, maybe we can...I mean, I think, these are again important questions and so one way...let me throw this out in terms of what we were thinking as the next step that can help us maybe further drill down on these. If you can move to the next slide and we can look at the matrix where we start thinking about some of the aspects of each of these, yeah.

So, one of the ways, and this could be very granular so I think we are open to your advice on this in terms of whether we take each priority need as it has been prioritized, you know, the bigger bucket, and look at that or we actually got down into some of the specific, you know, sub-bullets within each and those sub-bullets can be also tweaked I think based on our discussion today but also on your feedback.

So, one is that I think we need to...if we have these priorities then we need to identify, you know, at least what everybody thinks about each one of these in terms of what are some of the nuances of how we describe this because these, as we were just discussing, are fairly broad statements.

The second thing that we should also be thinking about in terms of our recommendations and which of things are in terms of the timeframe and what are needed immediately and what may be developed in a longer period of time and may take longer to develop because they are not that easy I think as we will mention there are some solutions here that technically they are being done probably in certain places but maybe there is a need for a policy change or a different incentive to make this work or some collaboration nationally in order to agree on some, you know, standards around this so that would be based on the timeframe.

And then who would be the stakeholders who would be required to address this need and I think that goes back to this point of where we are recommending maybe that this needs to be further looked into therefore leads to a lot of details that we don't have, at least in the next two meetings, time to come up with the answers to that but what we would recommend to the Joint Committee is that either this group or some other group look into that but then who would be those stakeholders that would be needed in order to address that need.

And then any example of a working solution that is already there because I think that would also be very helpful in informing the Joint Committee of where we think are these things have evolved in a way that has improved that experience or will improve that experience for others that may not have that solution.

So, maybe we can have some feedback on if this is a way to move forward and we can probably work on some of the language in the first column.

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

I'll just make a quick comment, this is George, I've been back and forth through the three priority items and all the slides, I think we're focused too much, maybe not too much, but I think we're focused very heavily on provider experience and I think we've left the patient off the list here and I know that when we improve provider experience that indirectly improves patient experience but I think there is more to patient experience that might need to be incorporated into some of these.

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

Yeah that's a very good point George. Would you also, as you look at these from the patient's perspective, are you thinking that it's just that the patient is not mentioned here and this will still be applicable to patients if they are provided the same kind of interoperability experience or are you thinking there are some unique aspects that have to be added to these lists from a patient perspective?

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

Well, so some of the former because for example if we can find the way to reduce cognitive burden, now we hear a lot from patients that...

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

Yeah.

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

Receive documents and they don't understand what they're reading or looking at and, you know, they're looking for a short digest of their recent experience, their recent encounter and they're receiving a lot more content that they don't really necessarily understand or follow and so some of what is on here would translate to a better patient experience, but finding data is something...I think even one of the quotes that we have on one of the slides talks about the ability for patients to find data and I don't know where we're addressing that. And I'm not a patient advocate expert but I'm thinking we're missing a few things here.

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

Yeah, I think it's on slide nine that you were referring to the consumer focus where...

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

Yes.

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

Yeah, it talks about...

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

So, George?

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

Easily finding...

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

George can I ask you a question? When we're talking, you know, we've got...we're talking providers, clinicians and then you've got patients under one slide. Clinician/patient encounter, clinician/patient...where is that in this whole conversation?

Because if we're talking about, you know, the instance of an episode of care where an individual is defined as a patient because they'll actually encounter a clinician then what about that relationship as opposed to let's put consumers in this corner, let's put clinicians on that one corner and because, you know, we've been hearing these arguments for decades and so what about the clinician/patient encounter relationship where is that in these recommendations? And do we care? Because I think we heard quite a bit of that on the testimony but it's nowhere to be seen on these slides.

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

Yeah it's George again, I think you're right. I think that we tend to think in these little silos, provider over here, consumer over here.

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

But, I mean, in health...

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

But the experience...

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

Yes...

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

Yeah, is...

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

Yeah...

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

Between the two.

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

Relationship is an individual is seeking a provision of care by another individual so if that's the cardinal pennant of the encounter why are we trying to arbitrarily put people in corners?

We should be talking about the actual things. How are these things effecting those two individuals or three or whatever that have to interact together in that clinical contextual scenario called clinical medicine as opposed to...because, you know, I hear the group navigating to digress again into, you know, we need...now we're going to be talking about health disparities and, you know, all that stuff and my God that's...you know trying to educate consumers and do they understand, you know, the surgery that was just explained to them. I mean, this is...it never ends.

But what about the physician or the clinician and patient relationship? Almost everybody that testified spoke about that in one way or another but it's nowhere to be seen in these slides.

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

So, is that something that you think is a recommendation but there are steps to that recommendation like to improving that experience or is that...does that fall under the role that patients and providers likely play and then what is their experience of getting information at the right place, the right time.

So, you are still thinking of reducing the cognitive burden but thinking of the cognitive burden in both the providers and patients with that relationship in mind as well as separately when you think of them.

Because then you...a patient having multiple providers or multiple clinicians that they are interacting with and similarly clinicians having multiple patients. So, there are certain things that are, I think, jointly at the point of care related to both in that experience where what access the patient has in terms of meaningfully using the data that is about them and then what access the provider has and to some extent those could be the same or they could be very different depending on the role and the relationship right?

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

Of course, I mean, you know, you could have a clinician that's a great historian and a fantastic sort of non-medical communicator, somebody who really knows how to speak to a patient in an understandable context, but how many times do you run into those clinicians today. Patients nod their heads up and down, consent for things they have no idea what we're talking about.

Philip Posner, PhD – Patient Reviewer – PCORI

This is Phil, as a patient I have to agree with the discussion but I think the final burden of communication is between the patient and the clinician...

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

That's right.

Philip Posner, PhD – Patient Reviewer – PCORI

Not from the medical record. The medical record is something that's going to be used one by the clinician to put down what is actually happening. Then if it's an open record the patient can enter that record with their wants/desires but the interpretation has to be done on a person-to-person basis. The average patient isn't going to be capable of determining everything that's in the record or why any individual test has been done or what the numbers are.

As a patient one of the things that is useful is when you have numbers coming back from tests you have normal values, you have the value from that particular patient and then you have a range and so a patient has the ability to look at that, but the average patient is not trained in the niceties of clinical terms and tests. I think that's up to the physician or the nurse practitioner or whoever the clinician is to put it in words or as I used to say one syllable or less so it's understandable to the patient.

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

Yeah so part of the challenge that I'm thinking at least as I'm listening to this discussion, this is Anjum, is that, you know, there is an entire experience of healthcare and to what extent are we looking at aspects of it which are related to interoperability and seeing how they contribute to improving that experience

because as you were saying that, you know, clinicians may have different strategies as well in terms of how they exchange information with the patient depending on maybe so many factors, depending on the conditions that they are treating, depending on the patient, depending on the history of the patient and all these things.

So how is the interoperability piece of that facilitating in the clinician to play that role effectively and also in the patient to play their role effectively in that entire healthcare experience.

So, do folks think that this, at least this matrix that we have in front of us, do we have that...I was looking at the matrix on the other slide, but could we move to the matrix and say, what is your suggestion in terms of proceeding? We have...Michelle we have two meetings before we come up with our recommendations?

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

I'm checking the calendar right now. Yes, so we have two meetings on June 14th and June 21st.

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

Yeah and so my understanding, at least from the initial task that was given to us, the charge that was given to us, was I think knowing that we may not be able to drill down into each of the needs that are going to help improve the experience where at least we will be able to identify what are those, you know, areas in which there needs to be further inquiry and further discussions nationally in terms of improving that experience.

So, keeping that in mind and the fact that we would only have just two more meetings to build on this further I'm open to suggestions...open to suggestions where, you know, how do we provide something meaningful or valuable at least for the Joint Committee for future action.

One of the recommendations could be for this Task Force to, you know, further drill down into certain aspects of this that we find are very important or it could be to suggest that there should be, you know, another Task Force that should look at this specific aspect or these specific aspects. Any thoughts? Comments?

Because I think some of the discussions that we have had we could almost also think of...maybe it's a discussion about some of the recommendations that are under each need that need to be either we can add stuff to it which we think is not covered there or we need to prioritize them further so that the intent of the priority that we have at least all voted on is clearly communicated.

So, it could be that we are...what we need are maybe additional explanations to make it clear in terms of what we mean by each of these topics. Is that where we are? Because that could be done asynchronously as well.

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

Yeah, I think that's one of the items actually that we need to work on is clear up the language. I think that the themes are probably within a good range but we do need to clarify the language so it's clearer on what the intent is of these recommendations.

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

All right. Anyone else? So, that's definitely something that we can do is we can circulate actually this matrix where you can all individually maybe either add or change the wording to suggest like what it should look like or maybe the explanations.

And as I said, in terms of moving forward we were thinking we should at least, if our recommendations stop at the point where we say, we looked at these, we realized there is more work to be done that we have to do maybe a root cause analysis for why this is happening but we didn't have enough time to do that right now but we suggest that this should be looked into so that we can, you know, build the right recommendations in this area. I would think that probably given the time that we had that would still be an acceptable recommendation to go from this Task Force.

Michelle, what do you think is that something that we could do as a Task Force as some of our recommendations that don't necessarily drill down to the solutions?

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

Yes, Stacey is that okay with you?

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

You know I think it's fine. I think we should probably further discuss the recommendations that we're going to put forth, maybe we could have a sidebar about it after this call.

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

Yeah, I think following today's call we'll need to integrate some of the feedback that we heard and think about what we heard.

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

Yeah, that's okay.

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

Actually some of that feedback can actually come more specifically in terms of, you know, language that people are comfortable with or they feel it is not clear here that would be very helpful for us to move this forward. It seems to me I think we can probably...now the other question would be whether we mainly explain the main priority needs or we actually address even the sub-needs in more detail as you see on this matrix like not only the left upper corner in the first cell but actually the first column.

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

Anjum in addition to what you said, it's Stacey again, I think the other thing that is also helpful is to just keep the charge in mind as to what each of these items, as far as the experience itself so whether it's the provider or the patient how it may...how we can actually provide a recommendation to improve

each of these independently to improve that experience on the backend for the provider or the patient like adopting automation, medication reconciliation so it removes some of the cognitive burden, like if you think about that and trying to take it a little bit more granularly perhaps that's something to consider when reviewing some of these items as far as the homework is considered to help structure even if it's not a granular recommendation but to provide some context and maybe some sort of focus to these since they are so broad.

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

That makes sense. So, do we want to, at least while we have some time I think...I mean, we'll definitely circulate this matrix as well so that you all can also give us a little more specific feedback in terms of the language and some of the details as have been pointed out where we could at least move from a broader category to a little more, you know, specific things that we think would contribute to improving the experience or for instance improving the experience of exchanging data as we heard in our virtual hearings as well and both from a patient and provider perspective I think that point was well taken in the sense that we need to make sure that we are looking at...and not only looking at providers and patients as two different entities but also as a team that is really working together and what would improve that experience.

But in terms of also what some of the specific things that have been contributed here, I'll give credit to Stacey in terms of bringing some of these things together as well, but it would be really helpful because you all are in the...working in different areas and so if you could also identify where we have things that kind of are already working and I know that Jitin had to log off because he probably got on a plane, but he also mentioned I think one or two areas where there is already work being done in the industry in terms of whether it is CommonWell or Carequality, or other organizations that are looking at this. It was also mentioned in our hearings as well.

So, that would also be very helpful I think and even if we don't come up with the exact solutions that we are recommending at least we can identify some examples of where these needs are being addressed. Does that make sense to the members?

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

I think it does, this is Jorge, let me ask you the three recommendations that you posted today and you went through do you feel that as a Task Force that maybe we should kind of go through those three recommendations as a team and kind of edit, if you will, the content so it's clear to everyone and everybody has contributed to the actual recommendations as opposed to inheriting somebody else's work?

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

Yeah, I mean...

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

That's a feasible purpose of having a Task Force.

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

Yeah, yeah, definitely.

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

...checking off boxes.

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

Sure and right now we have some time to do that so if that's something that you would want to get into I think that would be very helpful. How do other members feel about that? We can just maybe start describing each priority a little bit more in detail.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Sure that seems like a good start.

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

Okay. Should we start with the first one, ability to meaningfully utilize data. Any details that you want to add there or explanations?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

One of the things I was thinking when I was looking at this is the utilize open APIs has this weird undefined subject and who are we thinking is going to utilize the open APIs and does this also include the scope of providing them in the first place?

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

This is the other Larry, the other thing about that is there are also standards out there that do convey information, you know, all the IHE profiles and it's not clear when I read open APIs whether that's excluding those or not or Direct for that matter.

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

I see, so, Larry what would be a better way of putting this here? I mean, there is a Task Force on APIs that is working on APIs alone but...and from our point-of-view as we think of maybe open APIs being able to help with improving the ability to meaningfully utilize data. What should we state here?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I guess I'm not even sure how open APIs really focuses on the utilization. I think more of the important things are making sure that the data is transformed in such a way that it can or I'm sorry transmitted in a way that it can be put to work which gets to I think the automated and structured formatting.

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

Yeah, so we have it on the exchange as well and is this...let me ask others as well and maybe the ONC team can also help with that. When we were putting this open APIs here I remember what our discussion was where it was...was it also about applications that help in some translation or developing

insights for reducing the cognitive burden? Because that is how I was looking at this. Maybe there are applications that are developed like on top of the EHR that's helped in some of the reconciliation and maybe also developing insight for both patients and providers especially on the patient's side.

So, there should be some purpose for the open APIs right? Janet was that what you were saying or questioning at least?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Yeah, yeah I think so like how do open APIs play into this picture and it sounds like what you're saying is that either EHRs should improve the usability or should provide open APIs such that third-party Apps can do so.

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

Okay. And how about this first bullet which is around...we talked about automation and structured formatting. I don't know if we are wanting to remove the burden or are we just going to reduce the burden and that's not just provider as we were discussing it's also the patient. Any other like edits on this? Do you think we can state this differently?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Perhaps...I think there are two things here that automation and structured formatting play different roles. Automation is what the reconciler does in order to reduce the cognitive burden. The structured formatting actually is relying on the structured data so the sender has to provide that part of it.

So, maybe the two pieces are that senders should adopt discrete and structured, and code sets and blah, blah, blah so that the receiver whatever that is whether it's something they can use with an open API or the EHR making use of an open API, or whatever is able to process that data and use techniques such as, but not limited to, automation and I don't know different visual techniques and goals, you know, user goal-centered design whatever, you know, we want to come up with there.

But I think it sort of kind of...the first part is getting the data in a way that you can make use of it. The second part is actually making use of it.

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

Right, right, so it seems like this should probably be two different things then.

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

Yeah, Janet, I agree with what you were saying...

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

We have a typer with a lot of background noise if somebody could mute their line please.

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

Thank you. I just want to make sure I understood Janet what you said. I assume you meant the first part is the data entry correct? Getting the data into the system?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Oh, you're right that's, well, yeah, like I was thinking the data transmission into, but the first point at where it was captured...

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

Yeah, because, as you know, as we all know the data entry burden is a significant barrier from a usability clinical perspective. So, you know, that's a key principle here so the data entry into the system needs to be...now whether it's automated or not that's, you know, there's a whole camp and scoring on people taking both sides of that, but it's the data into the system what's a clinical burden going to be for the person having to do that.

And then the structure formatting to reduce cognitive burden I assume that means a computable format so that the receiving system is able to display the data in a cognitive reason/fashion for the clinical users and that could be, you know, if I'm working with my phone and I want to see it or if I am at a station clinically in the PACU I want to see it, or if I'm driving to a hospital and I want to hear it, you know, those are three different instances where I need to look at information or hear information so I can make a decision but don't tether me to the particular technology which some of the vendors here are kind of tethering people into particular technologies not, you know, people are so mobile today that, you know, we're documenting in between rooms, cases and you name it.

So, I think that automation is kind of a question mark because it's not the automation but it's actually getting the data into the system.

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

So, are you saying that we should not include automation or are you saying that...I get that there should be another step which is more of a data entry into the system should be simplified because that's part of the experience as well, as well then there is the piece about the structured formatting to allow for, you know, discrete data to be processed in ways that are convenient and reduce the cognitive burden. And then automation...

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

So...

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

There is the limit to what is automation and of what is comfortable to different folks, right?

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

So when you say adopt automation does that mean we reduce data entry burden? Is that the same thing when you say that? Somebody has to enter the data clinically.

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

Right, right, right, right. Well, yeah, part of that could be, you know, parts of that could be automated and then that could be simplified so it is in formats that are easy for someone to do it without disrupting their workflow that much.

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

Correct.

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

Which is currently the issue, right, which is currently a big issue.

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

Correct, I mean, if I'm in a clinical application and you upload the administrative, you know, billing information so I don't have to enter any of that information I can just do the minimal amount of entry that I am required to do then you're making my life a lot easier.

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

Yeah.

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

So, there is an automation there of counting that, you know, we have to know but you're not pushing that to the end user to have to do and that's the distinction that I'm trying to make here.

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

Okay, okay. And so that was a good discussion and then the third piece was around outcomes-based metrics, I think we had that discussion partly because you know...and that goes back to this point which are things that have to be done because the system requires you to do that and it may not be just because of the clinical requirements but it is more like either payment requirements or a requirement for protocols and guidelines. So, is that statement accurate or do you want to tweak that as well? Is that not clear?

Well, I think it's...I'll just assume that, you know, we can probably move on and if you have any input you will give it to us.

Let's move to the next, yeah, so ability to exchange data. Again, that's a very broad thing but we had...previously we had also built out specific points that would come under this in terms of what we mean by exchange data but then in terms of recommendations where we may be moving these were some that we had together, you know, any comments on the...so we talked about open APIs for the purpose of just moving data and from one place to another seamlessly, but then also the issue about authorization is another issue that came up. Any thoughts on that how we could present it here?

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

Well, so, I think again, the utilize open APIs is again sort of the same...

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

Right.

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

Issue as mentioned before. In terms of the authorizations, you know, I don't...I mean, I think it's okay I guess to mention OAuth but then you're drilling down, you know, talking about how it's used in Facebook and Twitter, and it seems like that is not something you'd want to have show up on a slide, you know, that you're explaining this there and, you know, and I also wonder is it OAuth or is it OAuth 2 that we're supposed to be...

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

Right.

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

More appropriate. So...

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

No that's a good point and we just put it there so that we could have that discussion of, you know, to what level do we mention like these specifics here. So, Larry would you rather have this described more in a more general form in terms of what is needed?

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

I think so. You know it just...it seemed, you know, we're sort of high-level and then all of a sudden...

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

Right.

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

Calling something out.

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

Yeah. Any other thoughts on that?

Philip Posner, PhD – Patient Reviewer – PCORI

Well, this is Phil, my only thought, again, from a patient perspective is one of privacy and so when you're talking about open records there is always the encountered problem of privacy with the record and so I think it's worth mentioning it. I don't think doing specifics and going down into the weeds and listing all of the potentials but I think highlighting the possible problem of privacy.

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

Sure. Yeah, so, thank you that's a good point. And then another thing that we mentioned just because of the work that has been done on interoperability and setting up HIEs in different communities at least at state level is about the variability which I think one of the...when we were having the initial meetings one of the charges that was included was looking beyond just the point of care to also looking at

population health and other aspects of this in terms of quality measurement and quality reporting as well.

And we had, you know, folks from Aledade who talked about ACOs and their challenges in getting data and then also from the public health and others, community HIEs that were talking about this. So, is that an important recommendation? And is it enough to say that we need to address that variability from state-to-state in terms of the requirements and cost?

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

Well, you know, one of the things that just I think isn't clear with that statement is whether you're talking about the fact that in different states they have different health information exchanges and they all have different ways of being connected and different structures and different costs or whether you're also talking about that each state has different laws regarding their privacy of information.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I'd say it's that and even different laws about sort of participation regardless of...again in some of them you must join and you have to pay to join even if you weren't deriving clinical benefits from it which seems kind of odd just leaving that I think as an additional thing on top of those things you mentioned.

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

Yeah.

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

Right.

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

Okay, so, yeah, so if we want to include this than we should probably include not only just variability in terms of requirements and cost but also variability in terms of privacy and then models of participation as well. So, also sorts of variability issues. We can explain that a little more so that if it has to be addressed in terms of improving the experience then it has to address all these issues right?

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

Right.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Right.

Philip Posner, PhD – Patient Reviewer – PCORI

Yes.

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

Great and then what about this last one which was around excepting direct communication. This one specifically talks about, because this was highlighted, you know, in our virtual hearings, communication from patients and I think it was also mentioned that sometimes it has associated costs but I would think

that there are...as I mentioned, I think there might be the same challenges to some physicians as well in terms of pushing data or sending data.

Philip Posner, PhD – Patient Reviewer – PCORI

No, I think I would put cost burden on the same level as we did cognitive burden in the previous slide.

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

Okay.

Philip Posner, PhD – Patient Reviewer – PCORI

Talking to some of my smaller practice clinicians that take care of me they're very burdened by having to do all of these things and maintain people within their practice to be able to handle all of these different electronic measures and communication and what have you. So, I think cost burden is an important thing to be addressed.

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

Okay, thanks Phil. Any other comment on this? So, is everyone okay if we also add providers in this in terms of being able to do direct communication?

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

Yeah.

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

Yeah.

Philip Posner, PhD – Patient Reviewer – PCORI

Yes that's fine.

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

Thanks. Next slide. And then the third one we were talking about was around ability to encode data and here we talked about standard formats for data to be used by EHR vendors and I think really partly this was where Jitin was mentioning that some of this is already taking place but what do you all feel in terms of this being at least highlighted as something that still needs to be addressed?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I think with the grid that you put together where we can indicate what steps have already been taken maybe we can cover that there.

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

Okay.

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

This is Jorge, on this particular one the VA and DoD have spent almost billions of dollars trying to chase this rabbit hole and today we are no more semantically interoperable than we were 10 years ago and so as people are volunteering...exercises of success on this they have to, you know, show that they can and by that prove that they can and by a factor of what. So, just because you say we're interoperable in a congressional hearing does not mean that you are. And so for this particular one you need to have real world clinical examples with clinical utility and the end user felt that you had improved their position of their services as a result of this semantic interoperable magic.

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

That's very well put.

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

This is George, I think what we see today are examples of capabilities, so you see standard formats when there are standardized test data but data in the wild are very different and there is...I think we want to...maybe we want to reword this one slightly so it's more about improving consistency and standardization of real world data, it's not so much...what we don't want to...I think what we don't want to do is say, and yet here's another certification hurdle to jump over...

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

Yeah.

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

Because that really hasn't been effective.

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

No that's great. And when we say...do we need to explain further what we mean by real world data? And do we want to say that that's, you know, all relevant data that is needed for clinical care or for improving outcomes or entering data from different sources?

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

I think real world data and I think relevant is some subset of what's out there in the real world.

Larry Wolf, MS – Principal – Strategic Health Network

Hi, it's Larry Wolf, I apologize for being so quiet but I've been pulled into three other things during the call. I am at the ONC annual meeting this week and a couple of things seem really relevant to this discussion about real world data, one of them is that the CDA's score card tool that was created by the SMART group in Boston is getting a revision for the 2.1 CDA specs, C-CDA specs and I think that speaks to this need of actually starting to look inside our standard documents and understand what's there.

And one of the...so I've got...so I think it's a great tool and I think it's really a valuable piece to sort of add to this commentary about what information is actually out there in the wild and how will this conform and how useful is it. It obviously has the problem of that as a score card tool it's on a public site and so if

you actually want to submit real CDAs you have an issue of how do you scrub them to maintain, you know, de-identified data and still have it be a useful thing.

So, I think there's something to be said there about taking that tool, which is getting a lot of depth in terms of what it does and finding a way to actually make it usable by healthcare organizations, healthcare provider organizations to actually be able to assess what their CDA documents look like at kind of a next deeper level and, oh, yeah, it complies to standards, well, how well are you using the standards, are you actually encoding data in a way that's going to be useful?

And the second related piece is the, I'm not sure what they're calling it, the challenge of creating tools to view and display CDA documents with to improve their usability and I think George has talked some about this as well, as Larry Garber's comments about the variability based on the individual of how they want to see the data, but I think both of those are acknowledging some of the complexity that we've got with the underlying data tools that we're trying to use to move information with and might be useful comments to sort of bring into, here are some things that are happening that are intended to actually do some of that drill down into what's in these documents, what is there data quality, how might they be formatted in ways to make them more readable, more usable. And I think those are two kind of foundational pieces to try to deal with. So, what's the data in the wild.

The other piece I've been hearing as kind of a recurring theme here is what really creates a high value usable experience whether it's for a patient or a clinician and I kind of feel like that's an area that begs for both high-level policy on its value but also a lot of in the weeds analysis way deeper than we'd ever get at a hearing to...

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

Right.

Larry Wolf, MS – Principal – Strategic Health Network

Actually drive sharing of best practices around creating usability. But I feel like those are both sort of like a dive into the data on one hand and a zoom out to policy around usability on the other hand or things that we create and incorporate in our comments or recommendations.

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

Yes, Larry, thanks for those great insights and I think definitely we can also add our comments where or in our recommendations we could say this is the direction that we know already is being taken but that's part of our recommendations is that we should look into this more deeply or continue in this direction if that's kind of what we agree on. So, those are good points, thank you. Michelle are we running out of time now?

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

Sorry, I was getting off of mute, yes, we need to go to public comment.

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

Okay, so we still weren't able to discuss these last three bullets but I think we had a good discussion so I would request and encourage everyone to kind of give us any feedback on, especially the different wording or if you want to add something and we'll send out this matrix as well. Okay, Michelle.

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

Okay, Lonnie, please open the lines?

Public Comment

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 queue. If you are on the telephone and would like to make a public comment, please press *1 at this time.

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

So, while we wait for public comment maybe we can take all the feedback that we heard today and start to fill out the grids based upon the conversation today and then ask you all to share any additional feedback you have on what was discussed today and what we didn't get to as well. So, we'll send that all as homework and in preparation for our next meeting. And it looks like we have no public comment. So, thank you all and have a great rest of your day.

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

Thank you everyone this was very helpful.

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

Thank you.

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

Thank you.

Philip Posner, PhD – Patient Reviewer – PCORI

Thank you.

M

Bye-bye.

M

Bye.

Public Comment received during the meeting

1. Michael Murphy: Patients are unlikely to adhere to "rules" for data submission, so it is likely that resources will need to be devoted to assess, transform and normalize these inputs before they are included in the medical record. An original version could be maintained for reference, but the data that actually gets displayed on a physician dashboard will need to be curated.
2. Michael Murphy: It is unclear how unstructured data contributed by patients will ever be comparable to structured clinical data and useful for providers to review. Patients will not be generally aware of the correct terminology for problems, conditions, allergies, etc. and in some cases, the information will not even be relevant to their treatment.