



Collaboration of the Health IT Policy and Standards Committees

Interoperability Experience Task Force
Final Transcript
July 12, 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 Joint 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, I'm here.

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

Hi, Anjum. Jitin Asnaani?

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

Hello.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Good afternoon.

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

Hi, Jitin. John Blair?

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

I'm here.

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

Hi, John. George Cole?

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

Yes, here.

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

Hi, George. Janet Campbell?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I'm here.

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

Hi, Janet. Jorge Ferrer?

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

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 –Veterans Health Administration

Hi.

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

Hi everyone, I'm here.

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

Hi, Kelly. Larry Wolf is on vacation. Larry Garber?

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

Here.

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

Hi, Larry. Phil Posner?

Philip Posner, PhD – Patient Reviewer – PCORI

I'm here.

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

Hi, Phil. Shaun Grannis? Ty Faulkner? And I believe Stacy is on the line from ONC.

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

I’m here.

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

Hi, Stacy. Considering where we are in the summer months, we have quite a good attendance so thank you all. With that, I will turn it over to Anjum and Jitin.

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

Thank you; welcome everyone again. This is a very important meeting because this is going to be probably our last...together so let me just start off by thanking you all for the great input that you have given and the commitment and dedication with which you all took time out of your very busy schedules on sometimes short notices to get with us and guide us in this process.

So we are really, really grateful for your input and cooperation in terms of getting meaningful recommendations to ONC through this process. And I was counting, so this is our 11th meeting and we have, I think accomplished a lot in starting from a very vague notion of what we wanted to do to I think being very specific now in some of our recommendations. So, again thank you very, very much for all the work that you have done and your patience in terms of working with us. I also wanted to recognize the work that ONC staff has done in supporting us and of course, my Co-Chair Jitin being very, very smart about how we have built this.

So this slide basically shows our journey and our next step is actually submitting our final recommendations to the joint committees. So today what we will do, next slide, is to basically focus more on the specifics of our recommendations, give you feedback from the discussion we had with the joint committee when we presented our draft recommendations and make sure that we have captured what you wanted to convey to ONC and to the joint committees as our recommendations and we’ll go from there. So, next slide. Next slide.

Again, I would basically in the first half of this, we will go through some of these slides that they’ve already seen, you know multiple times and we have gone through them, so that’s really not the meat of the discussion today. I think what we would like to do is really focus on the recommendations and the wording that has been used and the feedback we got on the specific recommendations. So, this was the charter, I think we are all aware of it, we presented it to the joint committees and this worked out fine. Next.

One of the things that we did want to highlight, which was...which we have added to this slide we had presented before was some of the members were surprised by the number of recommendations we had in which we were proposing task forces. And we probably didn’t make enough emphasis on the...or give enough emphasis on the fact that part of our charter was to propose new task forces that would take up work that we would identify needs, you know more input from a wider group. So we have added that to

this. And then the other thing which in the feedback was repeatedly mentioned by the task force members was that our recommendations should largely focus on steps that the federal government and ONC can take to solve the highest priority needs.

So, I think they wanted a little more focus in terms of our recommendations to be largely from a perspective where there is a role that federal government can play. So we have kind of highlighted that early on again. Next slide.

We presented to them the use cases from where we had started and there were...and you are aware of the five different use cases we had. We have details of it in the Appendix A, which people had to look at and some of them actually commented on the Appendices as well. But there was one I think observa...there are two observations here that we have made changes about.

One is under the shared care plan, people wanted to see at least a list of some of the team members because it was pointed out by some that even identifying team members is a step in the development of the shared care plan. So we have, in this case for the...for case two, which was an oncologist ordering, you know a blood test to a home health agency, we have added some of the providers. And there is a question mark because we weren't sure like to what extent do we expand this team, care team here.

So I don't know if the subgroup that had worked on the shared care plan or someone else wants to give us some input in terms of who else needs to be included. Obviously the patient or caregiver, primary care physician and the oncologist, a home agency were there, but then who else should be part of that team? Any comments there?

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

This is Larry, since Larry Wolf isn't on, I can say I'm Larry, not the other Larry. But I think that it's a great idea to add pharmacist there; I wasn't on this group but I think adding pharmacist makes good sense and I would say etcetera, you know because clearly the team in other scenarios just goes on and on and on and I do like the idea of having the pharmacist because it allows you to think beyond the traditional care team models that most people think; so at least that stretches it enough to say, oh, there may be others I have to think about, too. So I think adding pharmacist and then saying etcetera is probably all that we need to do.

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

This is Michelle, I know I'm not supposed to express my opinion but I'm going to. I think there should just be an e.g. there or etcetera, just so everyone knows its examples not the finite list of everyone it could be. Sorry.

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

Sure.

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

Yeah, that works.

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

Okay, great. Any other comment?

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

I was just going to say...this is John, as a clinician I agree with Larry, I think pharmacist is fine to add and also I agree with what Michelle said, I mean particularly around the comprehensive medication management that's coming along and having pharmacists involved, I was just going to second that.

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

Okay, great. Thank you. And the other thing that was pointed out to us then of the use cases was the use case around personalized medicine. And if you remember, very early on we had talked about that, but then we had also realized that there was a separate task force for this and so we had considered personalized medicine to be an important priority, but we would not...we considered that out of our scope because there was another task force working on it. So, in this case we have mentioned it here so that the linkage there and we have recognized that that was a topic that would be a good use case of course for interoperability experience. Okay, let's move to the next slide.

And these slides you have seen, we basically identify the top seven priorities, but we do talk to them about there were 35+ sub-needs and each one of them was considered important and they are important, so this was a process that we followed in terms of converting these use cases and looking at what would be the prioritized needs for making these, the inter...the experience in these use cases you know, better, you know improving that. Next slide.

And we have given the list of all the sub-needs in Appendix B so people can actually look at all...each one of those needs that were identified by all of you in our early discussions. We talk about the virtual hearings, next slide. I think we had covered this before and some of the quotations from that. Next slide.

And people really liked this formula here, this slide. I think there were several comments made about this being a good way of expressing kind of the interoperability experience of some of the highlights of this, so this was very well appreciated by the group that we presented to. Next slide.

And then we talk about the top three and some of the aspects of you know how we came about really developing our recommendations. I would say that you know one of the things that was brought up in just general discussions and as we go through I think I'll let like Jitin lead us through each of these recommendations, but overall there was the, you know recommend...there was the suggestion that we should focus on what federal government can do or ONC can do, in terms of our recommendations and even maybe some of our wording.

The second point that was I think highlighted generally was that we need to make sure that the patient perspective is brought out, that we have taken that patient perspective in most of our recommendations, you know and as you know, we had had that discussion that we are not just looking at you know provider perspective, we are looking at both patient, caregiver, provider's perspectives in terms of the interoperability experience. And so that was, I think it was more a matter of had we highlighted it enough, in terms of that we had taken that into account as well.

There was an overall I think, a lot of support for transparency in costs with it, with interface costs or others and also usability, and as you will see with the discussion of the recommendations that again there were some specific suggestions there as well. And finally I would say also a lot of support for the social determinants health data and shared care plans and how we can make that better.

So, I will hand it over to Jitin and again, from my perspective, as I have seen other task forces present and being part of the joint committees that I think this was...the recommendations in our presentation were very well received. I think people really appreciated the fact that we had focused on practical and also more focused on the interoperability experience and that we were...our recommendations were really forward-looking in that respect. So, there was I think just general...a lot of appreciation for the work that all of you have done, so again, thank you and congratulations on the work that we have put together. So, I'll let Jitin then drive us to the next slides.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, sounds great. Before we go to the next slide, so let me just underscore. So I agree with, exactly with Anjum's representation of how the meeting went; it was extremely positive, very engaged. We actually ran over time because of people's comments and discussion. It was ironic that some people did not...some members pointed out that they've never seen another task force recommend as many task forces as we did and yet most of the members of the Standards and Policy Committees also asked us to recommend more task forces for more things that they wanted to see addressed.

So what we'll do...so up front we made it clear that a large outcome of this workgroup would be recommendations for new task forces because we're out to outline the problems that need to be solved for the greatest need and create clarity around those relative to other problems which, you know are to be solved, but are not at the greatest need, and that's a process we went through over the last 11 meetings.

Over the next few slides, in orange you will see suggestions made by the FACA in terms of what more they'd like to see. We don't have to accept all of them, we...Anjum and I and...sorry, I should say Anjum, Stacy, Michelle and I and the rest of the ONC team as well, we put them in here so that everybody here on the call would have visibility into them. And we may decide as a group that there are some that we do want to address and some that we do not want to address or we have a different action item for.

Every time they talked about the federal govern...about making recommendations for the federal government agencies, I think they were talking about ONC and FACA, but several specifically referred as well to the levers that CMS and other agencies may have to move the needle on some of these interoperability experience issues. So we let's just...we'll keep that in mind as we go through this.

One last point, although there wasn't specific feedback about this, just from the sequence of the discussion it was quite clear that the formatting of the slides needed to be adjusted a little bit. So what we have done over here is, as you can see, we've called out the needs, you know through our discussion we came up with a set of needs for each of the three big buckets. So this slide for example, ability to effectively utilize health information; that's the big bucket we're addressing. On the left-hand side is one of the needs that we discussed.

On the next two to three slides there are more of these needs, but what we did was we called out each need in a separate row of this, you know multipage table, and right next to it, the recommendations just

because it was hard for members of the FACAs to understand what needs mapped to what recommendations and vice versa, when you put the recommendations on a separate slide. So that's just a formatting point. If there are no questions, I'm going to just dive straight into it, into the content finally.

On this slide the main point that people brought out of this item in orange was mainly they agreed with the recommendation that we should...there should be a joint task force to focus on reconciliation. They added the word...they asked us to add the word curation specifically because, and this is something we discussed here in this task force as well, you know there are some data elements which are not necessarily auto-reconcilable, but that doesn't mean that there's not a better way of presenting them so that they can be more easily reconciled or incorporated the right way.

So they felt strongly that we should...there was actually quite a rich discussion just around making that point that not everything is about auto-reconciliation but everything can improve the reconciliation process if things which are not reconcilable can at least be curated the right way. So we added a bullet point to it, it was a very minor edit, but we thought it was worthwhile. The words they used were curation, which is good enough I think, unless somebody has a burning issue with it and we can go on to the next slides where there are some much bigger recommendations that they made to us.

All right, on this slide, slide 14, this need that we articulated under effective ut...effectively utilize health information was incorporate effective user experience design as well as task centered and goal centered workflows. And obviously we had, at our last joint task force meeting, we had a long discussion around task centered and goal centered workflows.

What they...what the FACA recommended was actually they recommended a number of items and we have to figure out which ones we want to, we do want to actually incorporate here as our recommendations. They suggested you know we initially said sponsor challenges and pilots centered around user-centered design. They suggested four other things.

They said a task force focused on user design, usability standards and testing. Secondly, recommendation for increasing transparency of usability of a system; they were asking if we had any recommendations to that effect. Thirdly, recommend creating a national repository of test patient data against which Uis, sorry, that's supposed to be a capital "I," UIs can be evaluated in a standardized way. And fourthly, recommend that standards for user experience design be identified and required.

And when they said standards here, they're really talking about two different things. They're talking about things like hopefully most of you are familiar at least in words with the WCAG standards for web design accessibility, which were incorporated into Meaningful Use, I think it was WCAG level 2 that was incorporated in Meaningful Use, and clearly there were some members of the FACA who are looking for level 3; but in general, that's one kind of thing they were talking about.

A second kind of thing on which they actually spent some more time talking was principles for user experience and design. They felt that there was an opportunity for principles for design to be better articulated, and there were some workgroups out there who are doing it in sort of pockets and silos or within the bounds of specific companies, and that's something we should think about at a national level.

So these are the four sets of recommendations, let's spend a few minutes on this slide. I would love to hear what folks think about these recommendations. I certainly have my opinions, but I'd first like to hear what folks think about these recommendations with respect to the sub-need on the left side.

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

This is Larry, I'll kick it off. So one of the things that you know I think that all that they say here is good and in fact, the task force probably says all of the other stuff below it, basically make a task force and it's their job to figure out these other things, you know and that we could say they should consider those.

But what I'm more concerned about is that still doesn't solve the problem because so much of the problem in terms of experience is not just the software, but the implementation of the software and the training of the software and so while it's necessary to have a product that can accomplish, you know efficient goal centered workflows, it's not sufficient to make sure that you will get efficient goal centered workflows. And so I don't know how to address that, because it really does come down to an individual organization level whether you actually are going to get a good GUI and a good workflow.

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

Yeah, um...

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

Hello?

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

Hi, this is Shaun Grannis; just piggy-backing on Larry's comment. Is there space for evidence, you know evidence-based best practice recommendation for achieving these things? I'm seeing a pattern emerging where, now of course we all want standards and recognized standards, we want common you know experiences but how do you achieve that? You can define metrics but how do you get to those metrics and without guidance, some sort of evidence-based, best practice recommendations, it's unclear how we can achieve this.

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

Yeah, this is...

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

...this is Kelly, I...yeah; I'd like to add to that. So there are other sciences, informatics, information science that have looked at this and I think we should leverage that. I think the recommendation Larry, you did a good summary that these are all very you know, very impactful. The usability down to the implementation level is really spot-on for scaling as it affects the end users.

And so if we have people who are programming and following within the EHR what they're given just by the pure fact that they don't have a style guide to ask yes or no or no/yes and capital one means yes and A, B, C are choices; that affects the end user's heuristics, human factors, learnability, usability. Those really need to be respected because when an end user looks at that they say, well it's so inconsistent that it's broken and I can't use it; that will have an effect and I think that it's a very appropriate

recommendation to dive more into that and possibly leverage some of our other science friends in this space.

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

Yeah, this is John. I agree with all these comments, Larry's initially and then the others that followed on. One other thing I would add is you know, four years into this on the Comprehensive Primary Care Initiative in the New York region and some of the milestones, and some of them getting at this type of thing and trying to do that across a dozen different vendors I think really adds to the complexity. If we were talking about these four things with one vendor, I think all that was said applies; now add that, how do you coordinate that across many, many?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Hi, this is Ty. Continuing on, point number three around the national repository; to me that seems a...it's great by the way but it seems a little static so if we could tweak that to sort of move it to more like, we have these Connectathons every year where vendors come in and show that you know, they can actually connect, right?

So maybe like a UI-a-thon so that repositories actually being used and then we can actually either incentivize or you know, this might seem like a bad word but penalize those vendors who are not coming to these events to actually focus on what's the best of the best in the industry. So sort of an annual event, make it something that's you know, we can look forward to actually know how have we changed from year to year?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay...oh I'm sorry, please go ahead.

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

Yeah, this is Jorge; I wanted to echo that. I think that we have to you know kind of applied informatics in real clinical deployable systems as opposed to policy directives that may or may not be technically feasible. So I would encourage that we do look at a venue such as the one just mentioned that and I think in the marketplace competition, the best of breed will come out of efforts that because usability is what a vendor competes on, so there will be some device to improve their you know, the experience clinically for the user side. I think we should also have a really strong emphasis on applied, you know real-world clinical deployability not fictitious kind of you know, mindful thinking.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right. Okay. Okay so I'm going to...this is Jitin; I'm going to take a...sorry, I'm just going to take a note of that last one, because I think it fits in really well there. All right, so I'm going to...here's my suggestion then; I'm going to try to summarize what this first part of the discussion and you guys tell me if I got this mostly right or mostly wrong.

Maybe what we're saying here is...we're saying out loud three things, two of which I think we should put on the slide. The first thing we're saying is that our initial recommendation there, sponsor challenges and pilots centered around user-centered design; we can expand that a little bit more. There is certainly an aspect about the applied nature, which is valuable to bring in and should be a part of...and this is a good...that's a good forum in which to bring up and evaluate UIs for their ability to be utilized in the real world. And it can incorporate a point number three there around the usability of tests...of a national

repository of test patient data, which we do think is a good idea, and can be concretely used in the context of those challenges, the UI-a-thon, I like that term. And so there's some bucket...some recommendation that says ONC should sponsor these things or enable these things, like they're, you know like Datapalooza but it's focused on the UI and getting folks to actually demonstrate UIs that work and here's a standardized set of test patient data so that we know you're UI...how your UI really works.

Then there's a second recommendation that is that there should be a new task force, much like number one up here you know, focused on user design, usability standards and testing that will subsume points number two and four. It should...they should consider recommendations increasing transparency of usability, although that's sort of a bigger, different point; but certainly number four you know standards, principle of usage that can be incorporated there.

I think as this discussion went on right now in the task force, there's a third point that went beyond the user experience from a pure UI, UX point of view to a training point which is not captured here and is probably not appropriate to capture here, as it's...as this sub-need was very narrowly focused of user experience design, but that of course doesn't mean I don't, you know I want to ignore it. But I think those are the three things I heard.

So my own...the summary of my own summary is one recommendation around ONC sponsoring challenges, a UI-a-thon, etcetera. And a second recommendation to create a task force focused on user designs. Does that sound about right? Are we missing something?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

How did we think a task force would help here? I might have missed that part in the conversation.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That's a great question; this is Jitin. I think the task force could help here inf...so here's where I think a task force can help. We obviously are not in a position to do something like evaluate...we as in this task force, are not in a position to do something like evaluate standards for usability, like the WCAG standards or outline any principles for user experience and design. So a task force that was focused entirely on things like that, and potentially on item number two could help put some tenets in the ground as to what the industry, what the industry should follow. That's a stab Janet, what do you think? And I'm...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Sorry, I was unmuted. I guess my difficulty with this is that those standards and that transparency, like a lot of that already is built into the system that we have already. It's not as though we don't know how, like there are not reams and reams of good scholarly materials out there about how to do user-centered design and how to evaluate usability. And I don't think any of these things are foreign to us, so what I'm wondering is what that task force would do besides point to existing resources that don't necessarily even need pointers.

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

Well Janet; Janet, this is Jorge. Just like all the task forces that ONC has had, just the ability to focus a task force on key clinical deployable user-centered design principles where I'm...because you know we said and everybody has said, VA including that everybody does usability, but that still continues to be a relatively impactful problem area for most clinicians. So the task force, like all the other task forces that

we've had in ONC, can convene stakeholders to demonstrate and work as a team on some of these problems. So it's people coming together to solve some very difficult problems; that's what task forces do.

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

I support that statement; this is Kelly.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

This is Ty Faulkner again. Another use of the task force, and I also totally hear Janet's point that so much is available and that such, but perhaps we could come up with some sort of assessment from this task force like much like an HCAHPS is used for consumer assessment data provider services. So some sort of standardized satisfaction survey that is at least recommended from this task force and ultimately ONC that says, this is what we're looking at.

So you had the sort of watchdog groups like KLAS that's there and others that put out these surveys, but there may be adopted 30% or viewed infrequently; but having some sort of assessment nationally that brings these tools together and says you know here's some recommendations from what we know is the best, the best out here. And then consumers can then make decisions and providers and organizations on that versus the sparse data that we're getting from like the Black Book and other places.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay great. So what...so let me make sure I've kind of revisit this. So are we then largely in agreement that a task force here would be a useful step for us and is there any particular, are there any particular call-outs you would make for that task force over here, beyond what we've articulated so far? Anybody, can you guys hear me? Oops, did I lose the call?

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

No Jitin, I think this is good.

M

No.

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

You're still here.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right. Good, just want to make sure. Okay, so I'll tell you what, we'll go ahead, we'll take a stab at rewriting this, given the feedback you guys just gave us and send it to everybody. When we are done with today's meeting, of course we'll take that stab in a couple of days, send it to everybody so you can give us back more feedback in helping to detail out any part of that recommendation.

All right, let's go ahead to the next slide. So here are some other needs that we outlined when we had our discussions, the items in black on the left, for which we had no corresponding recommendations. And I just wanted to test with us whether that's really what we want to do or is there something different. So number one, reduce the burden of clinical data entry; we didn't actually make a

recommendation for reducing that burden and then a second one, incorporate the data into the EHR in alignment with policy, business and technical needs. Again we recommend...we talked about these as sub-needs which were important, but did not necessarily point to a single recommendation for them.

We could, given our last discussion, point the second one towards the same task force we just talked about potentially, but the first one is completely open. What do you guys think about that? It certainly looks like this...the items in orange, I see we gave no recommendations, but we did hear that we should monitor private sector progress on this, to the extent that's a fairly generic thing to say, like what does anybody think about this?

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

Just another...I have a comment; this is Jorge. If on the left side you're saying reduce the burden on clinical data entry then a recommendation perhaps might be to study what is it that people are complaining about with regards to clinical data entry. Is it the time that's required? Is it the level of effort to actually annotate, reconcile and document the clinical note? And so making a statement that we have so...did not have any recommendation, it would seem to me that it's more...has high utility to actually recommending that this thing we're calling burdensome clinical data entry to be studied further as opposed to we know it's a problem and let's just leave it there and park it.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Any other comments? Okay. All right. Okay so to that extent, incorporate it in...so, Jorge, can you repeat just one part of that? So you're suggesting we do create a...we do build it into the last task force or sorry, for the clinical data entry, the action item you suggest we recommend out is...

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

To further study the clinical data burden that clinicians are voicing is a real, and not just a perceived but a real problem with these systems.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

And is that a recommendation for ONC?

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

That's a recommendation for whomever, a task force, ONC, federal government, private...3630 anyone that's working in the studies. If indeed it is true that clinical data entry burden is a problem, whatever you're doing about it.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right.

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

Jitin, this is Anjum. I just don't understand that thing that falls in one of those categories that we also discussed in some of our last calls where we had identified a need, but we had not necessarily had the time to do like a root cause analysis on why this is not being fulfilled and I think what Jorge is saying is to for us to, or for us to recommend anything, we need to really understand why this is even happening and to be able to study that, so that I think is the gap while we have identified a need, and not have a

recommendation is because we haven't really gone into understanding what were the causative factors for this and maybe that's reflected in the wording of the recommendation.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, that's a good point, that's a really good point. All right, okay if there's no further comment, let's go to slide 16. So this is...this starts our second bucket of needs, right? I think the ability to encode data for syntactic and semantic interoperability.

So the first sub-need was built on the existing work done to improve the CCDAs; we didn't give any specific recommendation. The FACA suggested that we recommend that work just continue on this dimension; so it's not...of and a how or a game changer really, but just to recognize that ONC and particularly the ISA Task Force continue the work on this dimension. Michelle is the ISA Task Force still active? Is it something we expect will be reinitiated every year? Can you just give us a quick background on that to the extent you know it?

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

The task force is presenting their final recommen...well, they have two phases of their work; their first phase final recommendations will be presented at the July meeting and then they'll continue to work. So they still have additional work to do.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, they seemed to be asking for this themselves at the FACA meeting, so...

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

...we're happy to kind of say yeah, please continue doing what you're doing as part of this work.

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

This is Larry. I think there's something else that we could and should recommend here as well. I mean, there is a lot of work on enhancing the usability of the Consolidated CDA being done by HL7; so they are, you know besides the implementation guide, they're basically making a companion guide or updating the existing companion guide to give guidance as to how to actually use it.

And the other thing is that there's an Examples Task Force that is making sample Consolidated CDA documents that vendors and implementers can use to help them you know, do the building. So I think you know we could broadly say that ONC should support the efforts of HL7 to, you know who maintains the standard, to allow them to maintain and optimize and enhance the Consolidated CDA standard.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Great. Larry, this is Jitin; I might extend that only a little bit and say that HL7 is al...has also done a lot of their...a lot of the work...they always have, but particularly more so over the last five years, they've done a lot of the work in conjunction with other organizations like Sequoia Project or CommonWell or others

who are actively trading CCDA data and they should continue working with those groups as well as they get more and more real world input.

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

Sure.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right. Terrific. Okay, the second two needs identified here, identify a parsimonious set of interface terminologies, code data to improve the specificity of the clinical interpretation; we had you know we actually had three work streams with two of those work streams correspond to these two needs.

The...we sort of half-baked this when we last recommended it to ONC because we didn't actually define what these work...what do we mean by work streams? Are we recommending a task force do this? Are we recommending ONC should do this? Some other federal agency do this? Nobody do anything about it? And that's what we...that's one thing we should at least concretize over here.

So we talked about understanding the tools and opportunities that enable data to be efficiently captured. And second, to continue or renew efforts with terminology stakeholders to improve the value of existing code sets. And we just never recommended really who should do that; I'm wondering if really what we're saying is, we're asking ONC to do that, but I'd love to hear people's opinions based on what you know is work happening in the industry or in the government that this should just dovetail into.

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

I mean it seems that...this is Larry again; it seems that ONC shouldn't necessarily be doing this as much as supporting the standard development organizations that would be doing this kind of work normally.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So Larry, I agree. The place where I've seen ONC play a role and sometimes fruitfully, maybe oftentimes fruitfully is around coordinating with those standards organizations so that those...so their efforts are actually brought up to the front.

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

Yes, so coordinating and supporting, I think that makes sense.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, coordinating and supporting, yeah, that's right. But that's on number two. Number one, do we think that what we need here is another task force or just can somebody go out and do a study to understand what is being done out there. What do people think would be effective or useful?

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

This is Jorge; I...with regard...you're asking about the first recommendation?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yes, the one that starts with understand the tools and opportunities. So I think the thinking...our thinking here the last time in the task force was there should be examples of their...of users who are not frustrated with their EHRs and are able to get data captured in or input into the EHRs effectively. They may or may not be just using their EHRs; they may be using other tools. Somebody had made a

reference to, well actually I'm sorry, I don't, no sorry, there was no specific reference made or specific example given but being able to articulate those ...to be able to figure out what are those places where the data burden is being lifted is what this...what was behind this particular dot point. But actually understanding what's out there and bringing that to light, we kind of need to assign an owner to it and that's what I'm asking, who should be the owner of any work that goes around understanding the tools and opportunities, to enable...

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

Let's give it to the GUI task force.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Give it to the GUI Task Force as well? Maybe.

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

I was only half facetious on that, it might actually be a reasonable idea.

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

It might be.

M

Yeah I don't know that GUI...it's not a purely GUI problem, though.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, that's why Larry was being half facetious.

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

Exactly.

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

It's George; Jitin, I think you said a very important term here, so you, when you were talking about understanding the tools and opportunities, you said reducing the burden of data entry, which is our previous slide.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

...that enable it to efficiently capture...that's right, let's go back to the previous slide, maybe we actually could have melded those...

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

Though it might need to be on priority sub-needs number three where...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Can we go to the previous slide? Sorry, I don't control the slides...yes, you're right, you're probably right. In this case, so the pri...the first bullet over here really talked generally about the difficulty in using the HIT system and that being an impact on the demand for interoperability because it's already burdensome for the caregiver to utilize that system, far less to do other things that they might want to do with it like get data that they want to utilize for care.

This is a specific sub-bullet point, George, which is I...being able to capture the data that I want to in the granular code or whatever level is the right level of granularity of the code set that I want to in an efficient way. So it is, you're right, I think they do belong together; this one's a little bit more of a subset of capturing the data than this point. In either case, we have not made a specific recommendation for it because I think it was to Anjum's point around we have not...we've not really done a root cause analysis.

And so maybe this...okay, so great, so maybe it does fit into the root cause analysis that needs to be done to figure out what's going on here. Maybe it's as simple as that, there needs to be some work done here, probably as a work stream initiated by ONC to understand what it is that...where is it that this works and does not work?

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

Yeah, I agree; this is Anjum. I think that like there is more study to be done on the...even in this case that we were discussing, what are successful you know, examples of somebody having done this? But we know that that's not definitely the norm and so why or why not and what needs to happen in order to make this be the norm is, I think we need to understand the factors that will lead to this...case of the data entry fees and also capturing that data in a granular form that is understandable and interoperable.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

It almost feels like a Phase 2 of the GUI Task Force, doesn't it? If you kind of plot ahead a little further out, it almost as if you'd be asking the GUI Task Force to look at how data is presented, etcetera, which is Phase 1 and think about how it's captured. Or it could be a parallel task force for that matter, too; but it actually does feel like it's part of the...they're very correlated threads, they're just not the same thread because they're looking at two different parts of user experience.

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

Hey Jitin, this is John; I have a question for the group, just listening to this and thinking about your comment earlier about CMS levers or levers to be pulled. Is any of this stuff done in conjunction with CMS, because we talk about successes out there you know, where CMS is doing different payment models, they're probably seeing successes and some of it is around the implementation and usage of health IT and interoperability. Is there any work together between ONC and CMS for this type of thing?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

I am not aware, John; this is Jitin. I am not aware of any particular type of work happening here; it's something we could recommend. I think when the FACAs were talking about leveraging CMS, I think what they were thinking about was if there are existing forums or better yet, if there was a way to pull in the requirement into the ultimate decision of getting paid as part of...as CMS as an insurer; that's where they were asking for a recommendation. But to be, you know we can take it a few different ways. In the meantime, I'm not aware of a specific place where there's an intersection between CMS and ONC there.

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

I mean the reason I'm asking is...

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

This is Kelly...

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

...I'm sorry, go ahead.

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

...I was just going to add, I think that that's an excellent point you know, our operations and clinical informatics teams are torn in different directions by not having the collaborative viewpoint of who their answering to so if you include CMS and Leapfrog and others, I think that's an excellent point around collaboration that we should recommend.

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

Well I'm just thinking about CMS where they're trying alternative payment models and they're putting resources behind...I mean not only are they changing the incentives, but in some cases putting resources behind training and implementation that certainly...

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

Right.

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

...pulls in health IT. And some of these things we're talking about on user experience and training and all of that, I mean they're dabbling in that and they're getting results; I'm just wondering if there's some way that the two can think about some of this together.

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

Jitin, this is Jorge and just I wanted to claim I used to be a Medical Officer at CMS and I can tell you that firsthand that there a lot of divisions of CMS that this would...that they do as a payer and a regulator but that a whole quality QIOs, Quality Improvement Organizations that they run, by and large those are the arms that are effectuated to do a lot of this model-based purchasing experimentation with payer mixes and whatnot, but they're also using a little health IT as enabling tools to get the desired ultimate behavior change at the point of service. So, you know CMS obviously being a regulator is the ugliest girl in the room, but they're a significant one and it's one that needs to be considered.

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

Well and I'm also thinking about CMMI, I mean that's almost like a different animal...

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

Yes, yes.

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

...than CMS.

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

Right, absolutely.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

This is great...this is Jitin. John, are you suggesting, I just want to now tie that back to our recommendations now which are on a couple of pages. Are you tying that back to the burden of clinical data entry and understanding the tools out there for reducing coding, etcetera or are you tying it to the GUI work or are you tying it to both?

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

I'm tying it to all of this that we are talking about, I'm particularly thinking about that one recommendation section that had about four or five things from the FACAs and as you look through those, tho...I me...again, I'm thinking about CMMI and I'm thinking about some of those programs that have...that are incentivizing these changes and putting some resources, technical and financial resources behind changing practice patterns. And it gets into health IT and some of these things that are going on; I can just see synergies.

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

This is Jorge. CMS has a very concerted effort on training young physicians on how to code and so you know the administrative component of IT as opposed to just the purely clinical and so there is sort of overlap here because often times that's the tension that you're clinically driving a billable code as opposed to trying to clear the clinical nuanced note that actuated the depicts what's clinically relevant and...the patient. And so having CMS at the table I think is critical here.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, fantastic. Michelle, maybe we can discuss offline if there are contacts that you guys have at CMS and maybe specifically at CMMI who can...who we can get on the phone with and figure out if there's a possibility here for a time just to understand if it's...if we're making a feasible recommendation.

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

Yes, we'll work on that.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Awesome. And Jorge, if there's somebody you suggest too; please just let us know offline as well, if you have any right contacts there at this time.

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

Patrick Conway.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah, that would be helpful to talk to them and figure out if there is something that's a better recommendation here. Great. That's a great point, thanks John for bringing that up as a place where we can maybe connect all of this together. And we'll have to figure out how to articulate it but that's fine, that's secondary; first we'll figure out if that's a good...a way we can actually go.

Let's go forward again, let's go to slide I think 16 and maybe beyond that to slide 17. Yeah, let's go to slide 17. I'm just looking at the clock here and we're almost at 2, so we have about half an hour. So let's keep going, I think we have a good framework so far. This is continuing on the bucket of encode data for

syntactic and semantic interoperability; we recommended a task force for that focused on non-clinical data including standardization of it or the use of natural language processing, etcetera in it and where it's being used today. We never actually articulated a sub-need around it, around non-clinical determinants of data. We don't actually have to articulate one here; I just want to validate that we actually did think it was an important sub-need, right, because we can sort of back into one based on the recommendations we made. All right, not hearing any argument against or for, I'm going to assume it's for.

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

Agreed.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Agreed, terrific. Great, I'll take one to mean all, that's perfect. The second row over here, enable greater usability of the data, especially for quality measures. All right, so the FACA came back with a question, which we just couldn't address in the middle of discussion and we wanted to clarify here. We said greater usability of the data itself, especially with...measures.

And one person focused on the word usability versus usefulness in the data measures. I don't know if there's anybody here with experience in the quality management space whether you have a specific opinion on what word is the right word to use or whether we should be saying both or something else.

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

They're both important.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Both important?

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

In other words, if you've got the data but its poor quality, then you know it's not necessarily going to be useful. And if you got the data, but you can't get to it, then it's not usable; I mean, so I think you might as well put both.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay.

(Indiscernible)

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Anybody...everybody agree? All right, anybody have a counterpoint? No, okay. So the recommendations, we...so for this point, even though we articulated this sub-need, we never actually created a recommendation. And the two things that FACA members brought up was should there be some recommendation that any...some work dovetails with what NQF is already doing to improve quality measures. And two, should there be some monitoring of VAs work in this are with MITRE usability standards; I think the word was COKME standards, none of us actually quite knew what it was so we can go back to VA and try to figure out what that was, but I don't know if anybody on this call is familiar with VAs work with MITRE in the area of usability standards.

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

Yeah, this is Jorge; I actually work on a good bit of these initiatives at the VA. But I would say that as a FACA group, you shouldn't just self-select the VA, you should actually have federal health providers, an in-house service in DoD have as much to say about this particular space as the VA.

So my recommendation is not just the VA, but to include all the healthcare providers, Indian Health Service, DoD and VA and then, I'm not sure you want to self-select a vendor, which is MITRE here, but just you know introduce the language to suggest monitor you know federal, private industry initiatives that are working in this particular space because the MITRE initiative is here, gone tomorrow and a lot the work that we did at VA is contractual in nature which means that it has a timeline so, that way we don't recommend vendors on these type of committees.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right. Terrific, that's helpful, that's helpful Jorge. I'm...are we suggesting here that we're asking ONC specifically to monitor the work that NQF is doing to improve quality measures and to monitor what the federal agencies such as VA, DoD, HIS and others are doing to work on usability standards of the data? Is that what we just want to say over here? Anybody feel strongly otherwise, otherwise that's the one we will go with, just asking ONC to monitor. So it's not a very strong recommendation per se, but that might be appropriate, not everyone has to be a heavyweight task force or something like that.

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

It sounds good.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, okay; great. Let's go to the next page which is slide 18. All right, so this is now the third bucket, ability to exchange health information, so this is actually ability to exchange and is...so the first one's enabling easier access, and we talked about Open APIs; existing exchange infrastructure, building on what already exists; transparency of interface costs. But the FACA really honed in on that last one, which is the transparency of interface costs and asking for a recommendation for increasing that, as well as increasing the...a recommendation on increasing the oh, I guess the use of Open APIs. I guess, sorry, I guess those are two separate points, for some reason I was thinking transparency of Open APIs, but yeah, so transparency of interface costs and a separate one around increasing the use of Open APIs.

That's where they left it. I can think about sort of some methods you know, given what we...given the frameworks we have such as Meaningful Use or MACRA, etcetera for potentially increasing the use of Open APIs, although I'm almost scared to make that recommendation myself; but there are some fulcrums available there. But the recommendation for increasing interface cost transparency to the...it was really to the provider; in other words, how much should they, would they be expected to pay for one of the standard interfaces, one of the interfaces they'd expect to be able to get from a particular vendor, and how do you increase transparency there?

What do people think about those two particular points brought up by the FACAs?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

This is Ty; regarding the cost transparency, I believe the ONC did an initial study before the Meaningful Use Incentive Program which really helped set up the cost for the Medicare and Medicaid allotments over that five-year period. So perhaps taking a look at what are the costs and then sort of at least

making that available that says you know, this is what typical services are available and what those costs are, but just leaving it at that given that to start this with the EHR data and now moving to the exchange data, it would seem like a natural progression to say that you know, we've combed the industry and this is what we see and just leave it kind of at that.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So Ty, going back to the very first thing you said there, you said ONC has conducted or had conducted or should conduct such a study of the cost of using an EHR system for over a five-year period?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Yeah, that's correct, for those of us who've been around you know in '08 and '06 before the HITECH hit, the legislation that brought the incentive program, there had to be some parameters around how much the incentive was and so that study data is available in terms of what a provider cost would be to get an EMR. And that's mainly focused on ambulatory, although there was also offsets set up for the inpatient setting as well around percentages of covered lives and visits and all that stuff.

But that data helped set in place the understanding at the provider level and organization level on what the costs would anticipate to be based upon the incentive and then the provider and organizational contribution, so similarly to you know, we know that the HIEs vary right? Cost and service options, so taking a look at what's out there and really just saying here's what we have found and not necessarily saying one is good or bad.

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

So if you just bought a new car, how much did your tires cost? Well you don't know that because it was bundled in the total cost of the car. And also the cost of that car is different you know whether I have to drive it on a toll road versus a road that has no tolls. And so I think if we're you know, envisioning getting to a point where you've got a website and you can go see vendor As you know interfaces cost this and vendor Bs cost this, you know, they're just going to change their pricing model so that, hey, it's free with this vendor. Well it's not free; you're paying for it one way or another because the vendors have to be financially viable. So I think we're heading down a hole here that's going to get us you know, useless information in the end.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Okay, I think my recommendation was not to pinpoint vendors, but to do the general pricing approach, but I definitely hear you, I mean it's an area that the providers often raise as an issue, organizations raise as an issue and if there was sort of a, you know a model A, model B approach or model T I guess in this case, model T and model B approach on pricing, and leave it at that; it could help our providers actually engage more when they understand what the costs are for and how it compares.

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

Hi, this is Shaun, I've been having trouble with my phone so I've been speaking and I guess you guys haven't been able to hear me. I want to echo the comment about the tires and the car. When we talk about standards and interoperability, they represent sort of the ingredients like the sugar and the butter and the flour in a recipe and the way that people put these things together in different ways implies different cost structures, different economic models.

I am aware of almost no specific studies of the data interfaces cost in any literature anywhere. I worked with a graduate student about five years ago in economics to document how much the 2000 interfaces in Indiana's Health Information Exchange cost and we found wide variability based on a number of business factors. So just getting some, I mean the recognition that this is incredibly challenging to document, that it's deeply tied to your business model; I think there are some important things to say about interface costs, and I don't think the world really understands you know how those costs work or where they go. So I think there's something important here, but I think it needs some more framing.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Well let me ask this question, Shaun that suggests to me that it can be...if there are...if it does vary greatly and it is dependent on a number of business variables and to Larry's point, it could also just be a matter of how the costs are packaged into the total cost of ownership of let's call it the EHR, whatever the health IT system is. And it sounds like a study could actually be very misleading or force vendors to price in a certain way that may or may not actually have made sense for their customers relative to the rest of their pricing.

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

Well, yes.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

No, go ahead, that's it.

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

Yeah, so I mean the classic example, you know I obviously come with significant bias because I'm in a state with a significant, long-functioning HIE. But the reality is, many EHR vendors just bake into the price of the cost of doing business into their software licensing fees, the cost of an EHR, you don't even see an interface cost there, they just raise the licensing, software licensing cost enough.

HIEs or other data-sharing organizations on the other hand, have to build data interface creation; it is the service that they offer and so there is a spectrum, I mean...well, I was about to mention a vendor, but I was cautioned on earlier calls not to. I know of many different vendors who simply bake into their license...software licensing costs the projected estimated cost of the human capital it takes to build an interface.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right.

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

So I think there's a rich, unexplored territory here that folks just don't...I don't think there's great visibility into today.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So are we recommending that such a study is conducted, much as you did in Indiana, for example? Is that what we're suggesting that such a study be conducted nationally as well?

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

I think, I personally think it would be very useful if one can get at those details. It's very hard to get into the underlying business models of these vendors and so ge...I think it is worth the effort to understand the dimensions of this and understand well we all advocate that creating these data interfaces and exchanging data is expensive, often those costs are hidden and convoluted in a variety of ways.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay.

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

Can I ask a question...this is Anjum. So do we think that this topic itself is that important for the interoperability experience and for the ability to exchange health information, which was the need here, that it requires like a separate group to be...looking that all these factors, all these complexities around how the costs and technology are related with the business models and how they have been applied differently in different markets. Because it does seem like, I mean even from the comments from the task force members...the FACA members and just generally as we have implemented HIE solutions and Shaun was mentioning that that seems like a huge unknown in terms of what that cost would turn out; in each case it would be different.

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

This is Michelle, I just want to note that back in March, there was the Certified Technology Comparison Task Force and they did...they talked about this in great detail and so they provided recommendations back in March which we can share with this group. Those recommendations were to inform a report, I honestly don't know the status of that report. So we can...that up from across ONC but this has already been a topic of discussion back in the spring, which isn't that long ago. So I think that we should at least share those recommendations with this group as a level set of where things have already taken place.

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

This is Shaun, I second that motion; I'd love to see that document.

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

Yeah, that would be great.

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

Yeah, I agree.

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

You know...this is Kelly; I was just going to add to the concept of does this come in or out of scope, and if we talk about the experience of the end user as they're trying to provide the best, safest and most efficient care that they can, data liquidity is certainly a part of it and if we don't have interfaces that

allow data to flow, then we quite frankly are not doing a service to our patient-centered care models. So I do think that it is part of the scope of this.

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

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

This is Jitin, I'll second that but I'll say it slightly differently. When it comes to the perceived friction of user experience, this is domino number one. Once you get past this domino then you get to other things like how...is the interface good speed, bad speed, do you get batch or not batch?

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

Yeah.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Is it...how many clicks, etcetera; but domino number one is how much is this bloody thing going to cost me?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

This is Ty and I'm just going to also chime in for the consumer side, whatever we end up doing, I know we've focused on the provider, but trying to head off what is soon to come where consumers are actually paying for some of this.

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

Mm-hmm.

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

Yup.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

So should we...is our recommendation first a look back to that study and Michelle, I think what we need is both the study as well as the repercussions of that study because I think where this group would not want us to leave off is if that study went, you know was conducted...is now done and is sort of...

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

Well, it wasn't...it informed a report so I will share the recommendations and the report. I...there was a lot of discussion about this because they were just making recommendations about what should be in the report, so let me share that first and there might be additional need for discussion, so maybe we could have that over e-mail.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, that sounds good. That sounds good, all right, great; I feel good that we'll at least tackle...this is a big, very hairy problem and to both Larry and Shaun's points, it's also highly multivariate problem which

can actually...which is both good to shine some light on, but can also create more confusion in and of itself actually sometimes because all vendors do price themselves and package their products very differently.

Okay, the last point on this slide was, may...I...in some sense this is easier, but it's also harder because there are a lot of ways of doing this; recommendation for increasing the use of Open APIs. We've certainly talked about Open APIs. Michelle, I don't...I'm not aware if the API Task Force itself gave recommendations for how the Open APIs can...we can drive their additional usage and real world implementation. I don't know if anybody else here has a recommendation for levers we should consider utilizing, it could be for example again, Meaningful Use, MACRA or something else to drive it.

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

There definitely has been work around that as well. There was a former API Task Force that David McCallie and Arien Malec led. I'd have to go back to their recommendations because I can't remember off the top of my head, but I think there is something in there, Jitin.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Around how it can be...about how it can be accelerated? How its use can be accelerated?

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

Yes. So let me share those as well.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, why don't you share those as well. Does anybody else here have sort of a burning opinion on this? No; going once, going twice, nobody even thinking about Open APIs? Nobody been staying awake late at night thinking about them? Okay, all right.

Okay. Let's go to...okay so let's go the last row...sorry, the last row over here on this page; harmonization of policies from state-to-state; we called this out as an issue, as a sub-need that creates a lot of perceived friction, but we didn't actually give any recommendation around it. And I'm not saying that we have to, but I do call out that we have not given any recommendations. Does anybody think we should be giving a specific recommendation around this one?

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

Jitin, this is Anjum; just to remind that, and we were asked specifically if there was a recommendation on the state-to-state variation by one of the FACA task members.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Oh thanks, Anjum; yeah, that's right, somebody did ask it, I don't recall who but it was asked.

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

It seems to me it's been almost 10 years, five to 10 years since there was last a, at least that I'm aware of, a review of the variability of the you know, privacy and security laws from state-to-state and I wonder you know, if no one's aware of more recent analysis, I wonder if it makes sense to at least

encourage ONC to commission one to look at the variability and to see from that bas...is there any hope of unifying it or at least understanding it may help the groups that are working on how to convey privacy and security to know what the variations are that are out there.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Michelle, are you aware of any study that's being currently conducted from the Office of the Priva...the Chief Privacy Officer at ONC? Otherwise this might be a recommendation for that office, I would imagine, is that right?

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

Yes, that is correct. I'm not sure, but we could follow up with Lucia's team.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right.

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

And then one aspect...this is Anjum; and one aspect of this was also about the varying cost of doing business in different states and varies quite dramatically I think from state-to-state in terms of just the interoperability experience to be provided to end users.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup.

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

So I'm just saying that it's not just privacy and security, I think it's also the cost of doing business, of exchange.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

That's a great point, that's a great point. That's a really great point...as well as cost of...that's a great point. It might mean we need to talk to both them and to whatever is the new substitute for the HIE Program that used to exist in the Office of the National Coordinator, so we can figure this out.

All right, let's go to the last page...both good points, I captured them here. Let's go to the last page or rather slide 19; and ability to exchange health information. The one that we left completely open which the FACA has completely kind of zoned in on was the transparency of cost burden to the consumer, from the point of view of both provid...and it's a cost burden to the consumer, but the...it's the transparency of that cost burden to the consumer, to both the consumer themselves as well as the providers who obviously manage that relationship with the consumer. And we didn't actually give a recommendation on that.

So they asked whether we had a recommendation for increasing transparency of consumer's cost. Did anybody here have a suggestion around that or a straw man that they'd like to suggest for a recommendation we might either want to make or an organization we may want to defer this to, if it's not our recommendation to make?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

This is Ty again. I thought we had dovetailed this one in with the other one on the provider study, then looking at the consumer as well.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Actually, that's a good question, Ty. Is this also about the interface cost or is this the cost of healthcare?

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

I think it's a couple; so right now if we take a step back and say, what are we paying for now, right, to get access to data and what are our costs to share data with our companies? There's a lot of companies that are requiring health data now either it's that social data or it's data that could be pulled from a portal and are there...is there a freight to do that or is it just the utility cost, you know what is it costing me to involve myself in the exchange process as a consumer?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Is that something we...but is that something that's really captured by any previous studies that...

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

No, I don't think it is, but I think it could be inclusive of the overall recommendation for the provider visibility and then you know, maybe taking a stab at what's the consumer piece look like as well, under the same purview versus separating the two.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Right, agreed. So I guess I'm still...one place I'm just still a little confused, and I don't know if there's somebody who remembers our previous discussion well enough to answer this, but I think the...hmm. There's a technology cost and there's a cost of the healthcare itself. When this point was brought up, was it the cost of the technology which then has perspective for both provider and potentially the patient if they are somehow involved in...or is it the healthcare itself? And if it's a healthcare cost, well that's different from the...I think that's a different type of study than the cost of the health IT system as opposed to the healthcare cost itself.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Yeah; yeah, it could be both actually, you're right. Mm-hmm.

Philip Posner, PhD – Patient Reviewer – PCORI

This is Phil; so I want to break in as a patient prospect. We're all thinking of money as cost, but I also think about time, energy and the difficulty for patients to access this. I mean there's a cost involved in that for the quality of life.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Yup, utility cost, you're exactly right.

Philip Posner, PhD – Patient Reviewer – PCORI

Yes.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right, so it's to what you're saying is there is a co...and again, over here you're focusing on the cost of data exchange, right as opposed to of healthcare. That's just where I'm still unclear. I'd imagine it's around data exchange, but I just want to be clear that we're all speaking about the same thing.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

So, I'll give you a couple of examples; when we look at Aetna, for example, employees can make like \$300 for providing their sleep studies, right?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yup.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

And you know, there's the utility to provide that back and forth requirements and the necessity to do that. The difficulty to do that, if I'm a user that doesn't even have a computer at home, you know we always have to think about the low...the least of these, right? There's a higher burden and almost an, I won't say unfairness, but a uniqueness to that consumer versus that consumer who's an MD or PhD and working in data science. So those are the things that utility costs really either bring a burden or it's an...almost an invisible burden, so to speak.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Got it, okay. All right, anybody else have any...we're almost out of time so I'm going to be very sensitive to that, since you have to open it up shortly. Anybody else have any comments they'd like to bring to this one in terms of any recommendation we may or may not want to make for increasing transparency to consumer?

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

I don't know; this is Shaun. I don't know specifically what we're talking about here. I think there's...whether we're talking about patients transmitting their data for research, whether we're talking about electronic exchange of data; I mean, healthcare data's been exchanged since there's been healthcare and there's a cost associated with that. And so I'm just...it's unclear to me what we're actually trying to get at here.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

All right. Michelle...

Philip Posner, PhD – Patient Reviewer – PCORI

I think this...where, just a quick thought. Since we're an interoperability task force, I think what we're talking about is the cost of accessing the data by the patient and by the clinician and that's a cost that involves both money and both time.

Ty Faulkner, MBA – Adjunct Professor – Lawrence Technical University

Mm-hmm.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Okay, all right. All right, this is probably where we'll just have to stop because we have to open up the lines. What Anjum, the ONC team and I will do is we'll take a stab at this based on all this great discussion, and thank you again all for thinking through this so much and so well.

We're going to...we'll incorporate our feedback, send it back to you in the next day or two and ask you guys to please share back offline data. If you...we'll depend entirely on your offline comments; if we really don't get enough in the way of offline comments, we'll try to convene another meeting, but it'll be great if we could figure this out offline, because I think we're very close to most of these and can probably cross over the line to a really good product by just doing this offline. But with that, I will thank everybody again for such a rich and active discussion, as always; you guys are awesome and I will turn it over to Michelle so we can open it up for the last couple of minutes.

Public Comment:

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

Lonnie, can you please open the lines?

Lonnie Moore – Virtual Meetings Specialist – Altarum Institute

Sure. 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 at this time, please press *1.

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

So while we wait for public comment, as Jitin said, we'll work on getting something out to all of you and I've already sent Altarum some of the items that we discussed today, so that should be going out shortly. And it looks like we have no public comment. So thank you all for your dedication to the task force, hopefully you'll stick with us through the end and give us any feedback that you have, based upon what we send out. And just want to thank you all again.

We had a few comments in the chat and so we will send those out as well. So thank you everyone, and have a great rest of your day.

Multiple speakers

Thank you.

Public Comments received during the meeting:

1. David Tao: This is David Tao from ICSA Labs. With respect to a usability task force, have the recommendations of the earlier HITPC Implementation, Usability, and Safety (IUS) workgroup been adequately taken into account. That workgroup presented its recommendations to the HITPC in May, 2015, so we should avoid re-plowing the same ground if there's a new task force.
2. David Tao: Suggestion: I believe that transparency of interface costs is already covered in the "Transparency and Disclosure" provisions of ONC's 2015 edition certification rule,, which I think are still applicable under MACRA.
3. Shawna Koch Mishael: It may be minutia but for the interface cost survey could be done well by surveying HIEs and ACOs.