



**HIT Policy Committee
Interoperability & Health Information Exchange Workgroup
Governance Subgroup
Transcript
August 15, 2014**

Presentation

Attendance (See Below)

Operator

All lines are bridged with the public.

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

Thank you. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Interoperability and HIE Workgroup, and it's the Governance Subgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Also as a reminder, if you are not speaking, please remain on mute so we can avoid interference, it would be appreciated. I'll now take roll. Carol Robinson?

Carol Robinson – Principal – Robinson & Associates Consulting

Here.

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

Hi, Carol. Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Present, good morning.

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

Hi Chris. Anil Jain? Anjum Khurshid? Anne Castro?

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

I'm here.

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

Hi Anne.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina
Hi.

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

Barclay Butler?

Barclay P. Butler, PhD – Defense Health Agency

Present.

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

Hi Barclay. Beth Morrow? David Sharp? Deanna Wise?

Deanna Wise, PMP – Executive Vice President and Chief Information Officer – Dignity Health
Here.

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

Hi Deanna. Elaine Hunolt? Jitin Asnaani? John Blair?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Here.

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

Hi John.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Hi.

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

John Lumpkin? Mariann Yeager?

Mariann Yeager, MBA – Executive Director – Healtheway, Inc.

I'm here.

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

Hi Mariann. Melissa Goldstein?

Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University

I'm here.

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

Hi Melissa. Tim Pletcher? And Tony Gilman? And from ONC do we have Kory Mertz?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Here.

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

Hi Kory. And Kate Black?

Kate Black, JD – Health Privacy Attorney - Office of the National Coordinator for Health Information Technology

Good morning, Michelle.

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

Hi Kate. So thank you, everyone. Before I turn it over to Carol and Chris, I just want to make everyone...make it known that we have a few new members that have joined the group since our first meeting. We have Elaine Hunolt and Barclay Butler who will be federal ex officio members. And we also have John Lumpkin, who has been added to the group, so, welcome to them and with that, I will turn it over to Chris for some opening remarks.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Thank you so much, Michelle and welcome to the new members. I welcome all of you to the first listening session for the Governance Subgroup. And before I lead us off, I wanted to thank Michelle and the staff from the ONC. Having just joined the HIT policy committee, I am in awe of the work they do behind-the-scenes to get events like these lined up. So, I very much appreciate all the work. I want to thank Carol Robinson, my Co-Chair, who has been helping me get aligned with this and get started on this. And most importantly, I want to take this opportunity to thank all our presenters today who have taken time out of their busy schedules to join us for this listening session and to inform us on their thoughts and their experiences.

Looking at the rationale for the Governance Committee, our overall goal is to enable exchange, but what motivates us to do the exchange are a number of things. Number one is, we care about safety, we want to reduce duplicate testing that exposes patients to pain, cost, radiation other exposures. We want to improve diagnosis-making opportunities. We want to be more effective, want to reduce delays, we want to reduce duplications and will want to improve diagnostic approaches and we want to reduce cost by avoiding unnecessary efforts. We are in changing time, we're moving from a healthcare system that addresses individual patient needs to population health.

We're managing complex care of large groups of our citizens, with it we need exchange of information, and we have to assure that we create an environment when it comes to HIT that reduces the likelihood that we introduce no errors. I'm a programmer and developer, I've never developed anything without introducing a new and unintended and sometimes negative consequence. And one of the things that we are charged with here is to make sure we deliver a product, a governance product that assures outstanding patient...the outstanding exchange including also outstanding patient matching as part of the underlying structure.

So, what are the topics that we believe that this group will address and if you're not, we will prod you when we have a chance to ask questions of you after your presentations? We are interested in gaps in the interoperability policy, as it exists, so we're looking at consent, data use, liability, security issues. And how the government, mainly through the tools that are available to us like rulemaking, can create a common base to improve exchange. What are the high-level rules of the road that we need to get exchanges working and active? And what are the core set of requirements to participate in this exchange?

Today we will have two panels. The first panel...in the first panel we will hear from providers, pat...payers, and from the patient perspective. And in the second panel, we will have exchange service providers to inform us. So I am very much looking forward to be educated today, to learn from you and I am excited to listen to your testimony and have the opportunity to ask questions. With this I am going to turn over to Michelle for introducing our first speakers.

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

Thank you, Chris and thank you to all of our presenters today. Just a few logistical things before we get started. As a reminder, please keep yourself muted if you aren't the one speaking. To our workgroup members, in the agenda that was sent around, it includes the questions that were asked of our presenters. So, just as a reminder, if you want to review the questions that they are answering, it's at the bottom of the agenda. And to our panelists, just a reminder that your comments are limited to 5 minutes and I will give you a 30-second warning before your 5 minutes are up and then I will ask you to kindly wrap up your comments.

And we will go through the panel, so each panelist will present and then we'll open it up to questions from the workgroup. And to the workgroup members, we will be using the hand-raising feature within the webinar so you may be put in the queue for questions. So as you see at the top of your screen, there is a little icon with a man with his hand raised, if you just click on that, it will put you in the queue. And when we open it up to the question portion, we'll just go in order of the people that have raised their hands.

So with that, I am going to open it up to our first panel, which again is provider/payer/patient perspective. And on the first panel we have Henry Wei from Aetna, Alex Harkins who is a patient, Amy Feaster from Centura Health, Greg Wolverton from ARcare and Craig Behm from MedChi. And hopefully I pronounced all your names right and I'm sorry if I didn't, and it's probably MedChi, sorry. So, Henry Wei from Aetna, if you are ready please go ahead.

Henry Wei, MD – Senior Medical Director, Clinical Innovation – Aetna Innovation Labs, Aetna

Great, thank you so much. All right, I have one request which is to get the claims attachment standard right, that's about it. From a payer perspective, we are, how should I delicately put this, not harassing but contacting physician offices on a daily basis and to solve interoperability problems, you kind of just need to look at the fax machine. Yes, I understand that HHS/ONC has solved for a number of use cases where for physicians and hospitals and other providers need to communicate with each other.

But stand around and watch their front desk and look at their fax machine and you will see that huge volumes of clinical data are moving back and forth to big huge companies called health insurers. Specifically two types of transactions, one is when we request clinical documentation and this is usually part of adjudicating a claim to figure out if we can pay for something. But we heard mention of duplicate testing before, guess who really cares about duplicate testing, the payers and by the way, the patient increasingly so because they are on the hook for a lot more cost than they ever used to be because of cost shifting by employers and others. So if we can solve for one thing, it is to get that clinical document over to payers in a machine-readable fashion and in a secure fashion.

There are technologies to do this today, and you are seeing the introduction of X12 wrapped around HL7 consolidated CDA documents, which I'll advance in an official form as akin to putting a burrito inside of a pizza. No, there's nothing inherently wrong with it and you can certainly eat it, but it is kind of an unusual combination. We have much more direct protocols today and we should make sure that as we are solving problems for providers to connect with each other, that we leave them almost agnostic enough to the use cases so that they are durable enough to handle other cases.

I will finish with this final note, we have to solve for patient mediated health information exchange. I worked with the White House on something called Blue Button and this is how health data moves today. Patients take typically a huge binder of information from point-to-point. There is really...it's not so elegant ways to do that today, digitally. But we are trying to do so and if anything we need to keep pushing on that, in part because the health literacy of these patients needs to be supercharged with apps and other third-party add-ons that can help them understand not only their healthcare, but their healthcare costs as well. So I would be happy to take any questions after that but please, please, please don't forget we actually need to pay for something at the end of the day. Thanks.

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

Thank you, Henry. Is Alex Harkins available? Are you ready?

Caitlin Collins – Junior Project Manager – Altarum Institute

Alex, if you are speaking, you are on mute.

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

Okay, we will go to our next presenter and then go back to Alex. Amy Feaster?

Amy Feaster – Vice President, Information Technology – Centura Health

Hi my name is Amy Feaster. I am with Centura Health and we are the largest healthcare provider in the state of Colorado. And, should I go through the questions along with my answers?

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

I'm sorry.

Amy Feaster – Vice President, Information Technology – Centura Health

Should I go through each question along with my answers, is that kind of what we are doing at this point?

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

However you want to answer. You have 5 minutes to just go through as much as you can.

Amy Feaster – Vice President, Information Technology – Centura Health

Okay, excellent.

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

Whatever works best for you.

Amy Feaster, MBA – Vice President, Information Technology – Centura Health

Okay. What exchange use cases do we support? We primarily support direct messaging where we send C-CDAs for transfer of care to primary cares and then any providers that our clinicians identify as the next provider of care and we send to both internal and external providers. Our challenges with the direct messaging is our ability...many of our providers in our community do not actually have direct addresses yet.

When we started our project only 22 in the state of Colorado had direct addresses, so we had to put together a team of people to go and convince providers to sign up for direct addressing. Many of them weren't really sure what that was and what we were asking. There's also a lot of paperwork involved, we have contracts and we have to get things notarized for each provider that we're convincing should have a direct address. There is also reluctance on our provider community because they are a quarter behind us for Meaningful Use, so they are not even really turning their attention towards that, at this time they are starting to now more.

Let's see, what business practices by providers and vendors are currently blocking information following patients? There seems to be a competitive environment between insurers, providers and hospitals and the HISPs and it can make it difficult to obtain information. So what would be great is to have a national direct address book that we could tap into instead of having to go, I tried getting some addresses from another HISP and they would not share them with me. So, it would be great to have a national address book.

The other issue is that everybody's addresses seem to have...not everybody's, but a lot of them, their HISP name in the middle of their address and so if somebody switches HISPs, then they have to switch their address. And at least in our EHR, we actually store...we have to store the direct addresses in our EHR, so if a provider changes their direct address down the road, we might not necessarily know about it, so it would be great to be able to access a national address book, so we don't have to store those in ours. And then providers, as they change their addresses, we would have access to that.

Umm, let me see. And then some of the C-CDA stuff, the information on it may be old, they can be difficult to tell what is relevant. And audit-logging standards, at least to my knowledge, aren't as well defined for direct messaging for the EHR vendors. Also, it would be great to know, we know if we actually sent something to a HISP. We don't act...get a receipt if somebody...when somebody opened it or somebody actually had looked at that data. So we don't have that functionality right now. So I think I will stop there, those are our main challenges.

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

Thanks, Amy. Greg Wolverton?

Greg L. Wolverton, FHIMSS - Chief Information Officer – ARcare

Yes, thank you very much for the opportunity. This generates a lot of a water cooler talk, frankly, with my peers in any of these subjects, but specifically for ARcare, we are in a multi-interstate environment. We have got two different states, but we're currently supporting or testing referrals, discharge summaries, care summaries, lab results and immunizations. And I'm hoping in the near future that we are going to be able to support XDS.B and have consumable C-CDAs, CCDs.

I feel like there are unique challenges surrounding each of those use case categories, but in the end I feel it comes down to not being able to have a clear-cut method or solid standard across the board for vendors and HIE operators to disseminate data in a streamlined manner. A good example of this would be that we deliver services in two states, but we have two different sets of requirements for each state. This just raises the cost for development for the vendor and ultimately raises cost and operational expense for us to maintain different connections and information streams. And I am sure we are not alone in that when you start looking at the national environment.

As far as business practices and things that are currently blocking the information, I think the largest factor, and again you get the water cooler talk with this, is blurring the lines between competitive and cooperative or collaborative relationships. Determining how to share data without sharing your competitive advantage is challenging, but crucial to the initial buy-in and overall success of the HIE. Nobody wants their competitive environment, if you will, exposed.

And I think the secondary factor is, HIEs are having a difficult time convincing hospitals and larger primary care providers to hop on board with them rather than forming their own HIE. Simply, the hospitals are finding it very expensive to onboard with the current HIEs and they are starting their own, which again does not go to the benefit of the HIEs that other people may be in. So in the HIE obviously the more the merrier because that is where you are going to get your information. That is not what we are seeing, we are seeing more HIEs been created.

What should be taken at a national level to help address the governance challenges? As much as this is just cringing me and paining me to suggest, I really think we have to have some sort of national patient ID established. It is a sensitive subject, nobody wants to take it on, but we have to have a way to pull us out of the local, regional or state play and realize that we are in a travel...people travel, our patients travel outside their local areas and they should be able to access informed healthcare treatment. Much like the banking industry, you can access your...the ATM and access your account anywhere in the world for that matter, in a well-designed, fairly secure environment. I mean, it is not perfect, but I think in end patient care cannot be improved unless all their information is available to all sources of care and throughout all the delivery systems. It is that important.

We go back to the monitoring, what could ONC do to better monitor or identify successes and challenges? I think patients and providers, and I can speak as a patient and as a provider organization, nobody wants the big brother mechanism of monitoring. Again it goes back to the national patient ID, I think we are looking at two different things, but this should be left up to between the vendor and the client. However, I think a partnership between the vendor, the vendor's client and the government has to be a must. Again I go back to the banking industry, but the government must not own any healthcare data, but work with the patient and the provider to provide strict oversight and formulate a substantial penalty for any misuse of any of the health information. Again, it is almost like a regulation of the banking industry to where you have these safeguards and mechanisms in place and we all feel good about going to the ATM for the most part. We should feel as good going somewhere else and have the assurances that our healthcare is safe, but then also all providers have access to all of it. So, I appreciate you all giving me the opportunity to present at least my thoughts to everyone. Thank you very much.

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

Thank you, Greg. I am going to try and go back to Alex. Alex, are you available?

Alex Harkins – Patient, Portland VA Medical Center; MyHealtheVet user

I am. Can you hear me now?

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

We can hear you. Please go ahead.

Alex Harkins – Patient, Portland VA Medical Center; MyHealtheVet user

All right, well good morning and just a little background on me. I am a 69-year-old Navy Vietnam disabled vet receiving all my health care from the VA Medical Center in Portland. I have been a My HealtheVet system user since that time, well, since September 2008. Since August 2012, I have been a volunteer supporting other veterans using that system as well as the providers using secure messaging.

And just recently I have started to support the virtual lifetime record implementation, at the Portland VA.

I am a Naval Academy graduate, Class of 1967, and have numerous information technology and business management postgraduate studies. I have been asked to present my experience as a patient using the My HealtheVet and in particular, the Blue Button download. And with that, I will ignore the five questions, if you don't mind. And a disclaimer, I speak only for myself expressing my opinions and not for any entity, including the VA.

So what is the VA's My HealtheVet, and that is within E and not Y? It is 10 years old. This online e-Health portal allows VA patrons to view, print, download the bulk of their electronic record, including doctor's progress notes. The vast majority of the records are available just three days after being signed by a physician. Patients also send non-urgent automatically encrypted communications to primary, specialty and administrative healthcare teams to request or change appointments, discuss symptoms, request medication renewals and ask billing related questions.

My HealtheVet also allows VA patients to order prescriptions, view lab results and appointments, tracks vital statistics, research health conditions, all in one convenient place. One feature of My HealtheVet is the Blue Button download. One may select types of data and the range...and the date range as well as the form, text, PDF, or CCD, which is continuity of care document. To be forthright, the CCD form does not work for me personally and I have a trouble ticket submitted since last September, and my patience is wearing.

Do I use it, you bet. The most used function is prescription refills, which is integrated into our own VA pharmacy, which US postal mails directly to the requester. Sadly, one cannot make appointments; it is supposed to be coming. But seeing appointments, future and past, is very helpful. Downloading the medical chart that is, using the Blue Button has become invaluable to me. I can review labs, consults, reports, primary care visits. I find what I read is not what I heard in a visit and that is not the provider making a mistake, it is my listening and remembering and sometimes those details matter. I do occasionally find a misstatement of a provider or health technician side, all of which have been very minor. Note we can only see radiology reports, not the images at this time.

Now I come to what the VA calls secure messaging, which some liken to e-mail, but it is not. Without going into the mechanics, suffice it to say it is secure and protected, so personal and protected health data may be interchanged and I, and many other veterans, patients, have really taken to this method of communication. The VA specifies that it is not to be used for urgent needs but on the other hand requires VA staff to respond within three normal business days. Pass three days and the message escalates causing others to be notified and reported up the chain. I use this messaging for prescription renewals, checking with providers on postop recovery, asking questions, arranging labs prior to primary care visits and so forth.

The Portland VA Medical Center has implemented several administrative departments on this messaging so the users may message billing and co-pay, travel reimbursement, the chaplain, enrollment and more. I find messaging is a godsend when compared to telephoning and having to wait substantially...substantial time on hold.

Another program just beginning for the Portland VA Medical Center is the Virtual Lifetime Electronic Record or VLER. As we are implementing, a veteran patient may authorize his or her medical data to be released to predefined institutions or health exchanges. Once this occurs, the hoped-for outcome would be that that should be he or she should receive care outside of the VA, his or her medical data would be available without further authorization or processes. This is supposed to be a two-way street so that the VA would see data from outside providers as well.

Locally in Oregon, the current significant participants are at the Oregon Health Sciences University, OHSU and it is physically connected to the Medical Center, and the Oregon Community Health Information Network OCHIN. At the last VLER telephone conference, I heard that the VA can retrieve OHSU data, but OHSU cannot retrieve VA data, so they are working on it. Regarding OCHIN, I am sure Tim Burdick will say more in the next session.

Now let's step behind the curtain, so to speak. The VA seems to copy relevant medical data from its VistA system to the My HealtheVet system, which imparts delays and sometimes non-availability. However, the My HealtheVet system has its own demographics, thus causing veterans to change contact information in separate places, confusing...

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

Thirty seconds.

Alex Harkins – Patient, Portland VA Medical Center; MyHealtheVet user

...the veterans...confusing, to say the least. Well, let me skip to the bottom. I have been down the roads before, dealing with HIPAA transactions, you guys got a lot to go, so good luck. Questions?

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

Thank you, Alex. We have one more panelist...

Elaine Hunolt, FACHE, PMP, CPHIMS – Health Acting Program Manager, Health Interoperability Service, Virtual Lifetime Electronic Record (VLER) – Veterans Health Administration/Department of Defense

Hi, this is Elaine Hunolt of VA and we really...

Alex Harkins – Patient, Portland VA Medical Center; MyHealtheVet user

Oh. Hi Elaine.

Elaine Hunolt, FACHE, PMP, CPHIMS – Health Acting Program Manager, Health Interoperability Service, Virtual Lifetime Electronic Record (VLER) – Veterans Health Administration/Department of Defense

...appreciate your comments...

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

Elaine, we are not doing questions or comments right now, we are going to go through all the panelists and we will thank everyone individually. I am sorry Elaine.

Elaine Hunolt, FACHE, PMP, CPHIMS – Health Acting Program Manager, Health Interoperability Service, Virtual Lifetime Electronic Record (VLER) – Veterans Health Administration/Department of Defense

Okay, that's super.

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

Craig Behm? Craig, are you available ?

Craig Behm – Executive Director – MedChi Network Services

Yes, I am.

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

Please go ahead.

Craig Behm – Executive Director – MedChi Network Services

All right, well thank you everybody for the opportunity. I am the Executor Director of three different advance payment Medicare Shared Savings Accountable Care Organizations. I am not a technologist or an HIE expert. Quite frankly, we view HIE as the means to the end, so as others have said, our goal is to reduce duplication of services, drive information to the point of care and hopefully provide higher quality, which should reduce overall system costs. So in that sense, our use case and our goals are really to have individual, often solo, independent primary care physicians, get the best information in near real-time so they can provide high quality, patient-centered care.

We are somewhat fortunate that in the State of Maryland, we have a very active state designated HIE, called CRISP, the Chesapeake Regional Information System for our Patients. They are enabling query-based exchange. They have a pretty robust encounter notification system, which allows admission, discharge, and transfer data to flow. And we have worked with them to receive that information directly through our ACO infrastructure, so we can somewhat more easily incorporate it into physician workflows. And I will talk a little bit more about workflows in a second. They also obviously support direct messaging, although I still don't see very wide adoption of those standards.

Overall, our plan of course is to support some kind of automated, global order entry and alerts, real-time gap reminders to support patient...more positive patient interaction...services. We certainly want to be able to transmit clinical information to and from referring physicians, emergency departments, other inpatient facilities, nursing homes, but unfortunately there seems to be a series of problems that I think I can break down in two broad categories.

The first one is the system. There seems to be no simple, straightforward, cost-effective way to integrate data into individual EHR systems. We have met with and worked with many vendors that are very good at functioning within their own ecosystem, but when it comes to transmitting things across vendors, across different systems and standards, there just seems to be still huge gaps at that last mile or the last couple feet of connectivity.

The second problem is really a personnel problem. When it comes to workflows, typically physician practices and even on inpatient side, there just isn't the time or expertise to develop good workflows that can use the systems that are in place today to their highest level of effectiveness. And finding the people who can build out the workflows, correct the systems and really develop the standards necessary, seem not to exist on a local level, at least not that we found effectively.

I will also say that like any growing technology and being on an implementation curve, we are hitting the issues that you expect us to hit. So, we still have a lot of workarounds when it comes to faxing information, even electronic faxes that then have to be manually transmitted...or grouped from a desktop into an EHR into the patient chart. But still, none of that data is particularly usable because it is not discrete or searchable.

I do think as far as business practices, I will echo what a lot of others have said in the sense that just more cooperation is necessary. It is still a very competitive environment, we still see EHR and now even care management...ACO management vendors, where they view data, in my opinion, as their sales and marketing tool. And so rather than trying to incorporate systems and create systems that can communicate with each other very effectively, they create one system and then try and expand that across an entire community. While I understand the business perspective, I am not sure that is good for the healthcare system, our physicians or our patients.

There also have been a number of issues that we have encountered, that I have encountered personally that involve vendors that make claims that they are meeting certain guidelines and standards and have certain capabilities. And they are, in fact, very far away from now. We have very simple examples of EHRs that are Stage 2 Meaningful Use compliant, but they do very basic things wrong. Such as requiring physicians to document a fall risk on each and every visit, even though it is not a standard of care or required any more often than annually. And that is because their reporting function pulls from that data field every single time you run a report. So it is up to the physician to document this information that they wouldn't normally document, because the system won't otherwise work and we tend to hit brick walls when we try and correct things like that.

So unfortunately, it feels like the devil is in the details for a lot of these things. That said, probably my recommended action would be to work on...

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

Thirty seconds.

Craig Behm – Executive Director – MedChi Network Services

...sure, would be to work on fewer specific goals and standards and actually have more broad system-wide goals. I like the idea of creating a highway and very broad standards for interoperability and then letting communities, businesses and public-private partnerships to figure out the details. But now it seems like we are trying to chase our tails on the details and we are missing the forest for the trees. So I look forward to the rest of the discussion and thank you again for the time.

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

Thank you everyone and thank you to all of our panelists on Panel 1. Just a reminder to our workgroup members, we are using the hand-raising feature within the webinar. So if you could use that to put yourself in the queue for questions, we would appreciate it. I currently don't see any questions in queue. Elaine, did you have a question?

Elaine Hunolt, FACHE, PMP, CPHIMS – Health Acting Program Manager, Health Interoperability Service, Virtual Lifetime Electronic Record (VLER) – Veterans Health Administration/Department of Defense

Well, thanks for the opportunity. This is Elaine Hunolt with the VA Veterans Health Information Exchange and we really appreciate the broad perspective of all the panelists. I think our approach, certainly in VA and for many others, is that the solutions to HIE need to be dealt with a toolkit. There are many, many tools in the toolkit and we appreciate the opportunity to have perspectives of what we are asking ourselves often is exactly the things that Alex addresses. What does the patient need? What does the veteran and the client need? How will health information exchange best serve them? Is it by increasing varieties of provider directories? For security? Better availability into the workflow? So, we just appreciate the opportunity to provide that. But let me ask this one specific question of the panelists, what are some of the other security issues that you all have run into in trying to implement or use Health Information Exchange?

Henry Wei, MD – Senior Medical Director, Clinical Innovation – Aetna Innovation Labs, Aetna

Elaine, this is Henry Wei. Hi, I was actually based at the VA when I did my tour of duty as an Innovation Fellow in DC, so appreciate the comments around VLER and My HealtheVet. In terms of specific security issues, one endemic problem across the ecosystem, on the payer side as well as on the provider side that we have seen is the need for digital signatures on documents rather than just on the transport protocol, namely Direct Protocol.

Direct protocol is a hermetically sealed pipe, but once that payload makes it out, we have to interpret that document from a legal standpoint as rigorously as we would any physically signed document. And maybe that is not so much a security concern, but it is an operational concern that we have had trouble sorting out, at least on the payer side. There are some efforts like esMD over at Medicare and CMS that have tried to solve for it, but so far haven't seen a specific standard emerge to allow a document at rest to stay authenticated.

Greg L. Wolverton, FHIMSS - Chief Information Officer – ARcare

Yeah, this is Greg Wolverton. I think I would also piggyback and also second that motion that Henry spoke to as well as far as the document at rest. I think that needs to be explored a little bit more, although not specific security, but it definitely is a concern of the ecosystem.

Amy Feaster, MBA – Vice President, Information Technology – Centura Health

And this is Amy Feaster with Centura Health. I would like to see more guidelines on who actually gets access to the information that resides in the HIEs. I feel that it is not very well defined and there is no

connection, so we give someone in our healthcare access to the information in the HIE and they leave, it can be an easy oversight to not remove their access because they are not connected to any of our security tables in our organization, if that makes sense.

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

Do any of the other panelists have any response? Okay, I am going to go to the next person in the queue, Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Thank you, Michelle. So first let me thank all the panelists, this was very interesting and somewhat thought provoking. One thing...one theme that I picked up on was that there was a desire to be able to identify organizations, primary care physicians as well as individual...so, there was a desire for a way to identify organizational people on both ends. Amy was talking about the need for a national address book for providers and Greg was talking for a need for national patient ID. So clearly, matching is not just a problem for the patient, but it is also a problem for those that provide services and receive information.

So my questions really focus on...right now on this particular issue, so Amy, this is directed to you. Do you have any thoughts on who should run such a national address book, what the appropriate entities would be to tackle such a problem if that was chosen as a solution to reduce barriers? And for Greg, my question to you is, the national patient identifier is clearly something that would help match patients directly. Have you thought about, you were talking about privacy and monitoring, have you thought about the possibility of allowing patients to have more than one of those patient identifiers to be able to have certain disease processes separated from others? And then I am going to put myself on mute.

Amy Feaster, MBA – Vice President, Information Technology – Centura Health

All right, this is Amy Feaster. I am not sure who should actually run it and I'm not sure who does like Healthway, maybe that would be a group, but I don't know how that group is connected. But I think it would be great that out of med school if the physician, they get their DEA number, they get their provider number and then at the time, they could get their direct address and then that stays with them throughout their career.

Greg L. Wolverton, FHIMSS - Chief Information Officer – ARcare

This is Greg, kind of to answer that, as far as addressing that, I mean I don't think anybody has the exact answer and I think, I mean, hopefully everybody's head together is going to do that. But...is much, much akin to our Social Security numbers, who needs to manage that, who needs to do it? I mean, obviously CMS appears to be, or HHS somewhere appears to be the most viable place to house that, at least from my communication with my peers and different people, that would appear to be an HHS thing. But having different numbers, I don't know if that is the answer. I think maybe having one number and then come back to privacy, as far as what each patient wants to be or in an opt out or for private things and privacy such as behavioral health and perhaps some other things maybe HIV diagnosis and things like that may be to opt out on.

Henry Wei, MD – Senior Medical Director, Clinical Innovation – Aetna Innovation Labs, Aetna

This is Henry Wei. I would argue that it is overdue, it was mentioned in the original HIPAA, the talk back in 1996. But if we go with any type of identity approach, you are going to have to overlay it on a wide variety of existing identifiers today. And I would say one of the most compelling ways to get folks to adopt things is not necessarily just by force of regulation or policy, but if you attach it to payment one of the reasons why Social Security numbers are so popular is you happen to receive money. When you have the right number, you happen to have your healthcare paid for by Medicare if you have the right number. So including, for example, something as simple as the health insurance ID inside of your clinical documents might seem almost babyish, but it is a good stopping point along the way.

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

Any other comments from our panelists? Okay, I am going to go to Carol Robinson who is next in the queue.

Carol Robinson – Principal – Robinson & Associates Consulting

Thanks, Michelle and thank you again to all of the panelists, it has been very informative. I am going to drill down a little bit on some of the things Amy shared with us and ask for a little more detail on two of the points you made, Amy. One of those points was around saying that you felt like there was maybe potentially competitive environment between HISPs and insurers and I wanted to make sure I caught that right. And if you could speak to what you are seeing in terms of that market, HISP market in Colorado or beyond.

And then the second question I wanted to ask you was around your comment about the audit logs for direct messages and particularly about the message delivery notification. Because I believe that is part of the Direct standard that HISP should be delivering an MDN and that your provider should be able to see that within their EHRs. And so if that is not being implemented effectively in certified EHR technology that would be something that we would want to catch.

Amy Feaster, MBA – Vice President, Information Technology – Centura Health

Okay, yeah, the competitive environment. We have reached out to other HISPs to get addresses for providers in our area that aren't on our...the particular HISP that we use and they have been very unwilling to share those addresses with us. So then that means we have to go out to each...they said we will go the providers and then we have to go to each provider and get their addresses, which is time-consuming and wastes a lot of time. If the HISP...the other HISP could just provide us with the, for example in our case, with the addresses for providers that have addresses in the state of Colorado so that we could load those because unfortunately, we have to load those into our system. Let's seen, I'm sorry, I forgot audit logs, there was a question around audit logs?

Carol Robinson - Principal - Robinson & Associates Consulting

Yes, I was asking about your comment about the difficulty that you are seeing in knowing whether direct messages are being delivered and if they are being opened.

Amy Feaster, MBA – Vice President, Information Technology – Centura Health

Okay, okay. Yeah, so we do get a report that they made it to the HISP, they landed in the HISP. We don't get a report if somebody opened it or not, that is from any of the HISPs that we deal with .

Carol Robinson – Principal – Robinson & Associates Consulting

Okay, that's helpful. And then on the address book or the sharing of addresses between HISPs. I understand the difficulty in sharing those and I also understand that the members of your HISP or the providers that have signed up probably signed a participation agreement of some kind. And that you know when, or at least you have some mechanism of asking them to notify you if somebody has left the organization whose address needs to be removed or access needs to be turned off. So in those address sharing concepts that we have seen happening around the country where flat files of direct addresses are being exchanged between HISPs, what would you recommend in terms of governance to ensure that one HISP also does not continue to publish and use a direct address that is no longer appropriate for a provider or a person who is left an organization?

Amy Feaster, MBA – Vice President, Information Technology – Centura Health

We do get flat files and we match those up with what we have loaded and what we do, we see any new adds and so we add those. I don't know if we've been making the assumption that if a provider is no longer in that, that we remove the provider. So, that could be...to me that is one of the issues with not having a national address book that we could go out and query. And so it would be real-time updated information because everybody trying to keep all their files in sync is really cumbersome and it is prone to errors.

Carol Robinson – Principal – Robinson & Associates Consulting

Thanks so much. That is all I have, Michelle.

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

Thanks Carol. John Blair? John, if you are speaking...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President - Taconic

Yes.

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

...okay, there you go.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Sorry, yeah thanks Michelle. And I really do appreciate the panel taking the time and giving us this good information. At the risk not getting a second chance in the queue I am going to throw out three questions one for Henry, one for Amy and one for Alex.

So for Henry, you talked about X12 transactions and gave the analogy of a pizza wrapped in a burrito. I would like to ask you if you do have suggestions on that. Just quickly let me go to Amy and Alex and land those questions, then I'll go on mute.

For Amy, you talked about several challenges, I'm not really surprised at any of that yet, unfortunately, because this is brand-new. And when I think back about e-Prescribing back around 2001, 2002 and 2003, you could have heard several of these and the same thing with HIEs. So, I am not surprised by this, but what I would like to know is, as some of these...you are getting past some of these with different providers, are you starting to see much usage yet and are you hearing much from providers about their acceptance or interest in this?

And then lastly Alex, it sounded like maybe you get all of your care at the VA, whether you do or not, what do you think about messaging outside of the VA system? It sounded like you really...this was beneficial and you would like to augment it, just comments about if it was ubiquitous for providers within and outside of the VA? Thank you.

Henry Wei, MD – Senior Medical Director, Clinical Innovation – Aetna Innovation Labs, Aetna

So this is Henry. The first question was about the pizza and the burrito and HL7 and X12 and the Montagues and the Capulets. This was by design by our country. We always thought that clinical and administrative would be wildly different functions, that providers and health insurers they were two different things. We didn't, at the time, foresee accountable care organizations that would bear risk and behave as a hybrid between insurers and providers. And my suggestion would be, and this is going to be provocative, that we might want to do this in a belt and suspenders fashion.

Specifically HL7 lives in a different philosophy, which is real-time or at least day-to-day movement of documents and transactions. Not to say that X12 doesn't, but X12 as a general standard, even outside of healthcare was designed for massive, massive supply chain data and huge batches of information. It can be delivered hourly, but mostly batches as opposed to real-time transactions. So specifically, if you can just get enough information into one of their HL7 documents to handle say the approval for a surgery or a hospitalization, in other words that prior authorization process. Or when you have to send in clinical data to approve another day in the hospital, that is a good start. And the other good start is just getting those pipes laid down, getting more payers both national and regional to set up HISPs and not necessarily worrying about the payload inside there, but something as simply...as simple as a care manager trying to schedule an appointment on behalf of the patient, say in advance as they are leaving hospital. If the regional hospital doesn't have a resource, we have lots of nurses willing to help out but how do you catch somebody on the phone just to make that appointment where we somehow securely send information and just ask the providers office for the next availability that would be nothing short of magical. So secure the transport tunnels and then work on the data next.

Alex Harkins – Patient, Portland VA Medical Center; MyHealthVet user

This is Alex can you hear me?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yes.

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

We can hear you, Alex.

Alex Harkins – Patient, Portland VA Medical Center; MyHealthVet user

Good, I seem to be having some problems with my phone. Yeah, that actually was a statement I was about to make when I ran out of time. And so looking to the healthcare data exchanges with outside providers, I would love to see that we expect a patient using the VA Blue Button to download, to receive data from all providers, VA and others, now that would really be something. And to bring on exactly what you said regarding the messaging, I think the messaging to outside providers would be absolutely perfect. In my own case, although I do receive the VA...total care from the VA, I have been sent to contract providers, I had my Mohs surgery outside the VA, being able to communicate with him through our secure messaging would be fantastic and if it was ubiquitous, totally invisible to the patient, that would be unbelievable. I hope that answered your question.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Thank you.

Amy Feaster, MBA – Vice President, Information Technology – Centura Health

This is Amy Feaster. We haven't seen or heard benefits yet from the direct messaging exchanging of information. One...we have issues in that there is a lack of definition of how much history should be included in the C-CDA, so when you receive it, some of the data can be really old and not useful. And we do a lot with sending of discrete, for example lab data, transcribed reports that land right in the provider's EHR real-time as the patient is seen and so that has proven to be a more useful mechanism for us so far with Health Information Exchange. And then of course we get medication information from Surescripts.

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

Hearing no more comments from panelists, I will go to the next person in the queue. Anne Castro?

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

Hi. Thanks to everybody for your testimony. I have a question about how you think governance of health information will interact with the development of...in the continuing development of new, reimbursement methodologies including accountable care interfaces, medical home, information exchange to support authorizations, continuation of care, coordination of care, case management and I'm speaking maybe more to payers on these questions. A lot of the commentary has been about enabling, but...and a lot of people have that on their minds, but governance is in the title of our workgroup, so I am asking the question related to governance specifically. How do think that will interface with where we need to go to get a Triple Aim on new payment methodologies until we figure out what works? But that is a lot of information exchange, so what you think about that in terms of governance, not enablement but governance once it is enabled? Thank you.

Henry Wei, MD – Senior Medical Director, Clinical Innovation – Aetna Innovation Labs, Aetna

Thanks. This is Henry, I would love to respond to that. I think the risk-bearing entities in the system should absolutely be participating in the governance of these HIEs. And to the extent that they can articulate the values that they are...and their objectives in governance and their focus on frankly implementing features that the vendors don't just happen to have, but on the discrete problems that they are trying to solve and the measurable clinical outcomes and cost savings they are trying to achieve. That needs to be materialized in the governance of these health information exchanges.

We ought to be compelling those players that are risk-bearing entities to measure the effectiveness of the collaboration between the providers and the payers for population health management. It should be metrics driven, governance on clinical quality and cost and not just opinion or political connections to vendors or what have it. And finally, I would say the biggest risk-bearing entity in the system is actually the patient themselves and we often don't really consider including patients in the governance of HIE, but it is important. However, considering that the entire health system is based around seeking experts, so although the patients may request something, what they need and what they want, and this is a very productive the statement and it's coming from the doctor, so beware. But what a patient needs and what a patient wants may be different from each other and it is important for a knowledgeable patient to have insight into the difference and be able to contribute.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

Thank you I appreciate that. Is there anybody else who would like to address that question? Thank you.

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

Thanks, Anne. One final question and then we are going to move on to the next panel. Barclay Butler?

Barclay P. Butler, PhD – Defense Health Agency

Thank you, Michelle. I would be interested in hearing what you think the degree of interoperability that could be achieved in the next two to three years? Like for example, with hospitals do think 80 or 90% of our hospitals could get there? How about group practices that have EHRs or maybe individual providers with EHRs or even remote providers that only have Internet access that don't have EHR's. And then two follow-ons, what you think about the use of incentives to encourage interoperability? Should we look at bumping up reimbursement by a percent if it is exchanged electronically? And lastly, what you think about using a return say of a referral as a trigger for payment? I will go on mute.

Greg L. Wolverton, FHIMSS - Chief Information Officer – ARcare

This is Greg Wolverton, just a couple of quick comments on that. I think from the group practice perspective, interoperability is very important to us because the more interoperability or the more components we have that are related to interoperability, the less expensive we can deliver the care. A good example of that that we have seen time and time again would be the non-repetition of lab orders, and being able to get that information, even images from a DICOM perspective. And it goes on and on and on, not having to repeat or duplicate expensive items of care.

The other thing is to be able to align the care in terms of patient centered medical home and understand what practice of care has been delivered to the patients that we would share it mutually. So I think it is incumbent upon hospitals to want to improve, increase and an include interoperability in their plans, just like it would be group practice. At ARcare, we plan for that, it is definitely in our knowledge management business case. I think it is very important though to increase. As far as putting a price on it, you know what, I think it would be a great thing to do, no matter which way you look at it. If you are able to share results and you're not able to repeat labs, what is wrong with incentivizing that for something that does not have to be repeated.

Amy Feaster, MBA – Vice President, Information Technology – Centura Health

And this is Amy Feaster and I agree definitely and I think incentives are always to great way to help with adoption. But also an even simpler solution might just be single sign-on with the HIEs from peoples EHR. And in Colorado at least, we don't have that yet. Our physicians do want to look at data in HIEs, so they are not ordering duplicate tests, but they have to sign onto the HIE and then search for the patient. Where if we can get a single sign-on solution, if all the HIEs had to provide a single sign-on solution that interacted with the EHRs, that would be a big step right there.

Craig Behm – Executive Director – MedChi Network Services

Yeah, this is Craig. I want to second what Amy just said. I am not sure, as much as I am also a fan of incentives, I am not sure that the barrier to full connectivity is the fact that physicians don't feel the urge to be fully interoperable. And so while incentives might make them try harder, it seems like there are other technological and business barriers that are really the problem.

And so until, for example, hospitals are not trying to narrow networks and build broader and more specific referral patterns, they are not going to have the same interoperability push that maybe certain accountable care organizations or other risk-bearing entities might have. So I think it is a broader issue and unfortunately we are not going to get very far in the next couple of years unless we look at the system as a whole rather than as individual pieces and incentives on individual players.

Henry Wei, MD – Senior Medical Director, Clinical Innovation – Aetna Innovation Labs, Aetna

This is Henry, just one final note. I think the incentives are best incorporated in the so-called value-based contracting because when we say incentives, we actually have to get very comfortable with incentives and penalties that are effectively economic drivers of behavior. You might be, though mixing two different concepts; one is an incentive or an economic behavior trigger and another one is subsidy and subsidy is different. In other words, is there an infrastructure need that the practices, the providers can't pay for today and that is a different story.

I am not sure about the answer to that quite honestly, I would need to see, from a payer perspective, what are the outcomes we are trying to achieve and does this investment actually return the right clinical outcomes as a result of doing this. We think it is true and it is incorporated into a lot of our accountable care agreements, but we need more data to show that .

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

Well, thank you everyone from Panel 1, we greatly appreciate you taking the time to share your experience with us today. We are going to move on to Panel 2. I am going to introduce everyone from the panel. So for Panel 2 we have Carl Dvorak from EPIC, Morgan from CORHIO, Luis Maas from EMR Direct, Tim Burdick from OCHIN and Mark Heaney from Get Real Health. So Carl, if you are ready, you...

Carl Dvorak – President – EPIC Systems Corporation

I am.

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

...can get started.

Carl Dvorak – President – EPIC Systems Corporation

Okay, great. I will try to move quickly and if I do have time left over, I would like to yield to Tim Burdick and if you have not read his testimony you should, it is actually quite comprehensive and quite good and he will need the extra minute.

So with regards to the questions, I thought I wanted to first maybe open up the interoperability topic slightly more broadly. One thing that people don't often count at this moment is the kinds of interoperability between systems, within a healthcare system or these high-speed, high-volume feeds off to HIEs. So, one of the use cases we support today are the standard HL7 traditional interfaces with about 20 billion data transactions per year over 12,000 different interfaces across our 320 customers to about 600 other vendor systems including 88 public health agencies, 18 research societies, 51 immunization registries across 46 states. I wish those numbers lined up better. And about 17 other research registries.

So for Meaningful Use specifically, we support the Direct protocol, which is reasonable for planned transitions of care, if I am going to refer a patient I can send a direct message, and that's clearly better than nothing. But it is a bit inadequate for the unplanned transitions of care, i.e. showing up in an ED and needing to have ED staff person call your record from somewhere else, may be back home if you're on vacation, whatever. So, for the unplanned transitions of care, we support the Healthway exchange standards, historically known as the Connect Standards or the NwHIN Standards. We think both are vital to solving interoperability in the country.

Today interoperability that we provide operates in all 50 states, includes about 900 hospitals, 20,000 clinics with another 85 hospitals coming online and 3000 clinics coming online in the coming year. And we connects to 26 other vendor systems, 21 HIEs, 29 health information service providers HISPs, and 28 e-Health exchange members with 20 more coming online. Those are typically...a majority of those are the Veterans Administration and the Department of Defense, I think we have got 16 live in VAs and 11 more Vas coming online connecting to customers like OCHIN. And we've got one DoD site live, another coming live in Hawaii in this coming year.

With regards to impediments, a couple things we've noticed, and I sent a fact sheet along. One of the things that we did a little bit different within the EPIC community is defined a simple rules of the road, a simple point of care authorization method and a single trust authority and we just activated it by default. So, we still use the normal standards-based transactions to move information around, but having that phone book, that trust and the point of care authorization has really made a huge difference. In the last 12 months, we've done 29 million transitions of care within that community and that includes transitions to non-EPIC EHRs.

We connect directly to Cerner, athenahealth, Allscripts, Greenway, eClinicalWorks has been very good work with. So we do direct EHR-to-EHR transfers as well as EHR-to-HISP and EHR-to-HIEs and that has gone just amazingly well. So one strong recommendation for ONC and CMS is, if we could create a Meaningful Use phonebook and anyone who takes Meaningful Use money had to register in the phonebook. If we created a Meaningful Use certificate authority and if we created simple Meaningful Use rules of the road, we would probably within 12 to 18 calendar months have an ATM for healthcare. And that would include in that supporting the e-Health exchange protocol as an unplanned transition of care protocol, we desperately need that at a national level. And our data shows that it is amazing in how well it works.

So, those are three concrete recommendations, policy, trust, technical requirements. Again, fewer standards always help a situation like this, so sticking with Direct and Connect for now, I would focus on excellence with those two before going on to try to create new things. There will be wonderful opportunities for new things in the future, but right now we should focus. The rules of the road I discussed.

A couple things I want to mention in addition on barriers. With regard to trust, I think in looking at the landscape right now, organizations like DirectTrust are doing some good work. But their target audience seems to be large HISPs, large HIEs, state-based organizations and the price tag and the amount of work that goes into establishing trust is far beyond what a small hospital, a small practice or even a modest health system can afford to pay and it's a gift that keeps on giving with long-term cost. So we would strongly recommend ONC take a hard look at how end user organizations can establish trust through a simplified, cost-effective vehicle. I know our organizations can establish industry-leading trust through certificates for hundreds of dollars and a couple of days' worth of effort to get the certificates lined up, as compared to sometimes hundreds of thousands of dollars to join and go through a DirectTrust type process. So definitely looking for a simpler trust model.

The second thing is consent model, and this goes along with segmentation of data...

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

Thirty seconds.

Carl Dvorak – President – EPIC Systems Corporation

We really strongly believe that at this moment in time, a consent model should allow patients to opt in or opt out and not go to elaborate into segmentation of records, because we think it will impact physicians trust, interoperability and also likely deceive patients. Because if you are an HIV patient, you can block the HIV test result, but the fingerprints of HIV are going to be laced through the notes and through the meds and through other things that will be clearly visible anyway and I think will undermine patient's trust. Any more...any other...I think I have covered the important points.

One more thing if I could, I worry that in today's world HIEs and HISPs are becoming more or less walled gardens unto themselves. And I've had a number of customer CIOs from North Carolina to Alaska report that the immunization registries are being held hostage by HIEs who ask for somewhere between 250 thousand to 700 thousand from some of these large health systems, simply gain access to the HIE. Even if they don't need to exchange information through the HISP, because they have got Direct mechanisms to access other health systems, they are being charged huge amounts of money and they're blocking access to immunization registries if they don't pay up. So I think that's a problem that we should take a look out. And I'll let go at that, thank you.

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

Thanks, Carl. Morgan?

Morgan Honea, MHA – Executive Director – Colorado Regional Health Information Organization

Thanks, Michelle. This is Morgan Honea from the Colorado Regional Health Information Organization. And I would like to thank the Policy Committee for the important hearing and for the invitation to participate. To provide some context for my comments today, a brief background on CORHIO. We are a nonprofit, public HIE in Colorado and we are one of the country's most successful HIEs as measured by size of provider network and data scope. Additionally in terms of sustainability, CORHIO has a very strong position as the fees collected from our participants go directly to supporting the network's operations.

One of the chief factors limiting information exchange is that most non-hospital providers are using EHR products that are not capable of bidirectional exchange of C-CDAs with structured data elements. Although most EHR vendors have adopted technology architectures that make C-CDA exchange possible, the products have not been widely installed. In Colorado we encounter many providers that have not been able to upgrade to the newest version of their software systems.

Secondly, the cost incurred by physician practices to develop exchange interfaces is a tremendous barrier. In Colorado we commonly hear from providers in small practices that their EHR vendors are quoting fees of more than \$10,000 to build connections to CORHIO. And for small and medium providers this up front and recurring cost charged by vendors for HIE interfaces is one of the most significant barriers to participate. And I...before coming to CORHIO was running a rural and frontier federally qualified community health center and I can tell you that my view is that this barrier affects the small and rural providers much more significantly. And those are the ones that could probably benefit from participation in the HIE the most.

Third, although health information exchange will ultimately serve as the critical infrastructure necessary to achieve system transformation and cost containment, comprehensive payment reform has been slow to develop. So until payment reform is implemented in a systematic way, HIE will still be viewed as...by some providers as a pure cost rather than an opportunity to generate revenues through risk-based or value-based contracting. And lastly, policy ambiguities around behavioral health and substance abuse data exchange have created a huge fear of liability and litigation and are driving critical healthcare providers away from participating.

To address the questions about federal agencies roles in overcoming challenges of implementing HIE, I would say that the State of Colorado has done a phenomenal job developing local healthcare and health technology solutions that work towards achieving the national goals. And this was possible in part because federal agencies have provided the necessary direction and funding that has allowed Colorado to develop the type of local programs that ensure success within our own communities. In Colorado, we believe all healthcare is local and thus federal actions should provide direction toward a shared vision and the appropriate resources for states to identify pathways that empower local communities to achieve that vision.

So that being said, when CMS and ONC finalized the rules for Stage 2 of Meaningful Use there was a missed opportunity to bolster HIE use by failing to include, as an option, the use of an HIE network and existing query services for the transitions of care objectives. There are numerous, successful large HIEs in the country such as CORHIO, that are able to better facilitate data exchange than what is feasible through direct messaging. And by not including the option of using an HIE network service in these regions with advanced HIE capabilities, CMS and ONC have forced providers in these areas to take steps backwards with regards to HIE technology.

We know firsthand that this has been particularly frustrating for hospitals in Colorado. Even though these hospitals are sending full patient summaries and lab results and HL7 transactions through the CORHIO network to community providers, they are now also having to duplicate data exchange efforts and processes by setting up and managing a series of direct message accounts. This has put a strain on their already limited resources that could have instead been put toward better patient care or more advanced interoperability initiatives.

So toward the topic of ONC monitoring of the HIE market, I would offer the most significant need is to monitor the for-profit vendors that are suspected of employing tactics that intentionally slow the growth of interoperability as part of their overall business strategy. We would also like to see...

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

Thirty seconds.

Morgan Honea, MHA – Executive Director – Colorado Regional Health Information

We'd also like to see the ONC increase monitoring of EHRs to make sure that they are incorporating appropriate data exchange technology standards within their certified products. Thanks, Michelle.

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

Thank you. Luis Maas?

Luis C. Maas III, MD, PhD – Chief Technology Officer – EMR Direct

Hi, thank you. We support all the exchange use cases based on Direct Project specifications for direct messaging. This includes the Meaningful Use Stage 2 use cases that rely on direct messaging and transmitting and receiving of transitions of care. The transmit portion of view/download/transmit and also general secure messaging. We support exchange between providers, between patient and provider and other entities. So we integrate with EHRs through our API and also through our XDR Gateway.

We have provided this integration as a relied upon component for certification for over 30 completed MU2 2014 certifications and there are dozens more in the process of certification, so we are in the backend service business for Direct. We also provide this as a stand-alone service for EHRs the support XDR and also as a webmail service for providers and organizations without EHR access or without Direct functionality in their existing EHR technology.

For us, we see the backlog for MU2 certification has certainly slowed our deployment, really the deployment of our partners to some extent. The backlog reduces the number readily available exchange partners in some geographic regions and the inefficiencies in the testing are unfortunate as more streamlined testing could accommodate additional parties in less time. For example, the trust processing module of our HISP software has been validated over 50 independent times in the context of different MU tests for different partner vendors. And as expected, it behaves the same way all 50 times.

Ultimately as far as trust and policy requirements, we feel those must be defined by the end organizations that are using our services, as they are the ones in control of electronic health information and the information that will be exchanged through our system. Our software allows for very granular trust policy definitions that can be unique to an organization or even a specific end-user. So we work with the entities to understand their exchange requirements and help them frame their own trust policies.

To that end, we definitely support the concept of trust communities to define and optimally enforce common policy and trust requirements. And to leverage scalable tools like trust bundles to provide reliable synchronization of trust anchors. We encourage customers to review established trust communities to determine which of these are suitable to their needs. As we are an early member of the DirectTrust network, we do find that many of our customers do come to us asking for this DirectTrust interoperability and ultimately the vast majority of our customers will select policies that is based on inclusion in the DirectTrust bundle. So that scalable mechanism is working.

We agree with the concept that an independent third-party evaluation of services such as provided by the DTAAP Accreditation Program will increase assurance that community profiles are in fact followed and also increases the value of any trust bundle backed by such programs. It is important for us that such a program include a mechanism to report and investigate any potential deviation from agreed-upon best practices, just to increase assurance in the whole program.

Factors limiting exchange, we find ambiguities and variability in the interpretation and implementation of the underlying specifications, the RFCs, the Direct specification, as well as differences in payload implementations and some differences and interpretation of the MU2 use cases themselves can result in interoperability problems. Direct is definitely working and we are seeing exponential growth in Direct transactions, so we're constantly monitoring and processing both internally and with our competitors to make sure the Direct backbone continues to function as the end customer expects. We do this through interoperability testing framework, such as within the DirectTrust community or through Connect-A-Thon sponsored by Direct Project. And also through one-to-one testing with key vendors that are identified by our customers and...

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

Thirty seconds.

Luis C. Maas III, MD, PhD – Chief Technology Officer – EMR Direct

Okay, we find a great benefit to the industry for overall interoperability by establishing these forums to identify these ambiguities and work towards consensus on how to address them.

We think discovery of direct address has been a barrier and we support adding direct addresses directly to the NPI record. We also support ongoing industry work to develop uniform directory-sharing policies. And then a longer note, we would like to see Meaningful Use criteria synchronized to best practices in industry. For example, MU2 requires only unwrapped Direct messages, which have known security issues and the industry, in fact, has moved away from them. So we would like MU2 criteria to require wrapped messages so that certified EHR technologies don't find themselves left out of future exchange. Thank you.

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

Thank you. Tom...Tim, I'm sorry, Tim?

Tim Burdick, MD, MSc, FAAFP – Chief Medical Informatics Officer – OCHIN

Hi, this is Tim Burdick from OCHIN. Thank you for inviting me today. At OCHIN we are currently operating an electronic health record in 22 states. We are doing HIE for federal programs, state and county programs as well. We are using EPIC's Care Everywhere. We have 30 plus lab Interfaces, 15 states immunization registries. We are also linked up with four different regional HIEs including the use of inbound unsolicited messages for ADT, imaging and lab results. And I think the idea of having the unsolicited inbound probably has a better value in the long run than the single sign-on with two different user interfaces.

We are also interacting with multiple research networks, VLER, SSA, Direct and Healthway. All of this work is extremely expensive, timely and difficult and time intensive work. We do favor at OCHIN stronger CMS and ONC incentives that would incentivize state and county and payers to align their work around HIE. We would also include in that the use of incentives of the Medicaid 90/10 Funding Program that would drive alignment.

I would like to talk for a minute about some of the HIE use cases that we have and some difficulties around that. In particular, we found that most of our HIE use cases are around regulatory and payer requirements for reporting. These reporting requirements are complicated both in that the measures overlap very slightly, such as slightly different reporting periods or slightly different patient demographics.

There are just frankly too many different measures at the state, federal and county levels for us to keep up with. There are too many different ways to exchange and submit the data, dependent upon the organization that is requesting it. And I agree with Carl that we need to limit and standardize the exchange technologies. And we need to just decrease the number of reports that are required so that we can focus our efforts instead on Triple Aim projects. This approach is having state, federal, county and payer report requirements does not scale up to a national strategy for high reliable, portable healthcare systems.

We also have a lot of difficulty just on the coding side of this. We need to define, I believe, as a nation one common set of simplified concept unique identifiers. For example, colonoscopies, there are 22 different CPT codes that represent colonoscopy but all of them are highly specified and there is not a colonoscopy CPT code just for colonoscopy not otherwise specified. It makes it very, very difficult for us to create reports based upon that.

A couple of examples of non-standardized reports that we have to do, our 15 different immunization interfaces are all different. It costs OCHIN currently more than \$120,000 per year just to provide the maintenance on those reporting and interfaces for immunization HIE. For the state of California, our mental health reporting is extremely complex for the short bill billing that's done at the county level. And that project alone is going to cost is more than \$300 to build reports and interfaces for the required regulatory HIE.

There is also a mismatch of goals for HIE and a lack of industry oversight. When we started looking at the Meaningful Use Stage 2 measure six for specialized registry, we found that there were certain registries that were run by pharmaceutical companies, but the transparency was lacking. There were also some registries that had unclear data ownership and data use agreements. There needs to be more oversight regarding that. There is also unclear financial value. Many of those registry reporting options cost more than \$200 per month per eligible provider, which would cost OCHIN more than \$10.8 million per year. So we believe there needs to be more industry oversight in that area as well.

Some regulatory issues, different states have different laws regarding the release of data to personal health records. California in particular has some unique laws, which need to be aligned with some federal goals for releasing patient data directly to the patients. We believe that there is also an over-interpretation of CFR 42 Section 2 relating to mental health and substance abuse records. This leads to data sequestration and also further leads to further stigmatization of certain patient populations.

On the patient matching front, we have had a lot of difficulty with patient matching, particularly in the OCHIN served populations. We have many patients with non-Anglo names. Their names are often spelled differently across different healthcare organizations. For patients who are immigrants from foreign countries who don't know their birth dates, the dates are almost always entered as January 1. These issues make it very, very difficult for patient matching. We would recommend if the federal government isn't able to come up with some sort of national patient index, at least a grassroots voluntary effort where patients would create a standardized naming and date of birth convention.

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

Thirty seconds.

Tim Burdick, MD, MSc, FAAFP – Chief Medical Informatics Officer – OCHIN

They would have cards that they would fill out and be able to present at registration, regardless of which healthcare organizations they were showing up at. We believe this would greatly increase the patient matching problem.

Lastly, there are multiple known issues with Direct, most of those have been discussed already. At OCHIN we have providers who may work at three or even four different healthcare organizations on a weekly basis. It is unclear to us how we will set providers up with different direct addresses or how we would direct messages if they had just one address. And we also wonder about whether patients will be allowed to have a direct address as well. Thank you.

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

Thank you very much, Tim. Mark?

Mark W. Heaney – Chief Executive Officer and Founding Partner – Get Real Health

Thank you. My name is Mark Heaney and I'm CEO of Get Real Health. I would like to thank the ONC and the Policy Committee for this opportunity. We are strong supporters of your mission and we firmly believe that great progress has already been made towards enabling patients to access their health data and to actively participate in their own healthcare.

By introduction, Get Real Health is a vendor specializing in patient engagement and connected care solutions. Our flagship product, InstantPHR, is a 2014 edition modular certified EHR technology focusing on patient engagement. Basically what it does is InstantPHR receives data from clinical systems and parses, presents and visualizes it and allows the patient to collaborate with their care team. Specifically we support the following use cases, patients viewing, downloading and transmitting health data, including C-CDA documents and the exchange of health information between patients and providers via secure messaging including the Direct and Blue Button Plus standards. Therefore we focused our comments on these last mile patient involved health information exchange topics.

We applied the interoperability improvements to date that have resulted from the work of ONC in these working groups. However, we have seen some specific challenges to the exchange of health information. The first challenge is really in getting valid and complete C-CDAs. And we have worked with more than eight high-volume MU certified EMR systems that have had difficulty producing C-CDAs that will pass NIST validation using the transport testing tool. Some of the most common issues that we encounter are missing required document sections or attributes, the presence of attributes or sections not allowed by the standard, improper identifiers, coded values and the handling of null sections.

The problem is when we don't get compliant, probably coded C-CDA documents, we are not able to effectively parse them in order to extract useful information for the patient. Also, our healthcare provider customers are struggling to meet attestation deadlines as a result of these issues. Therefore, it is clear the current testing and certification regime is not sufficient to achieve the government's intent of ensuring document interoperability.

Therefore, we recommend about ONC and other federal agencies should first provide better online tools for C-CDA validation, including tools that can validate specific C-CDA types interactively and programmatically. Secondly, provide robust sets of documented, compliant sample C-CDAs. And third, extend the testing requirements for MU compliance to include failure cases and cases with missing or null data.

The second major challenge that we are experiencing is difficulties in exchanging direct messages between patients and providers. Firstly, while Direct is specified, as the required protocol for patients to transmit health information, there's no corresponding requirement the providers actually be able to receive this data. Secondly, with Direct the sending and receiving systems must have a trust relationship, which is most commonly established through a trust bundle such as DirectTrust. Well, DirectTrust is a good approach for information exchange between providers, there are some challenges to using it...a single trust bundle such as DirectTrust for both provider-to-provider and patient-to-provider information exchange.

First, it is impossible for a receiving system to determine whether the sender is a patient or a clinician directly through the Direct protocol unless there is some other information source available. And then second, it is really impossible for receiving systems to really determine the identifier of the sender beyond a direct email address and the fact they have been validated by the sending system. Therefore, we encourage ONC to require a couple of new things for certified technologies.

First is, require that certified technologies be able to receive patient-generated direct messages. And second, support separate trust bundles for patients and providers and distinguish clearly between the two. We specifically recommend the use of the Blue Button Plus patient trust bundle for patient provider messaging in parallel with trust bundles like DirectTrust for provider-to-provider communications.

In closing, we believe that these issues are surmountable and they represent final barriers to the effective and meaningful information exchange between patients and their providers. We remain strong believers that the work done to date with C-CDAs and Direct are the correct approach for this kind of asynchronous, loosely coupled exchange between clinical and consumer facing systems. On behalf of the team here, thank you again for your time and the opportunity to present our side.

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

Thank you, Mark and thank you, everyone from Panel 2. So just a reminder to the workgroup members, if you could please use the hand-raising feature to put yourself in the queue for questions, I will now open it up to questions from the workgroup. Carol?

Carol Robinson – Principal – Robinson & Associates Consulting

Thanks, Michelle. I didn't think I was going to be asked to go first here. I have a couple questions. One, Mark I was interested to hear and have recently heard about organizations that are not turning on their inbound direct functionality with their EHR systems and that was quite surprising to me as well. So, can you speak a little bit more to that and how prevalent you may see that being right now? And then again, I have a couple of other questions. One about...I would like to ask Morgan or others, Tim and Mark perhaps about anything you may be seeing in the field in terms of the customization around EHR implementations. And whether or not having a tremendous amount of customization capability actually then impedes the interoperability of these systems because they are capturing different things in different places and not being able to read those and receive them correctly. So I will stop there and anybody who wants to jump in on that but...that would be great. Thank you.

Mark W. Heaney – Chief Executive Officer and Founding Partner – Get Real Health

Hi this is Mark. And so one of the things that we have seen with a lot of customers out there is that they are turning on inbound Direct primarily for the transition of care use cases. But that receiving direct messages from patients that are not directly connected to them through their patient portal or a secure mechanism...secure messaging mechanism that they have established has been a little bit of an afterthought.

In terms of customization of EMR as being a barrier to interoperability, I don't think that that is necessarily concern. I think that the standards for exchange can be separated from the interfaces used within the EMR and its internal representations of the data. So as long as we have the good standards, I think the EMRs can innovate, as they will to deliver the best experiences for their customers.

Morgan Honea, MHA – Executive Director – Colorado Regional Health Information Organization

Carol, this is Morgan from CORHIO and I guess I would just follow-up Mark's statements a little differently. CORHIO right now has 35 hospitals in the HIE that represents about 94% of the beds in all of Colorado, so a huge network. And although I am not a technologist, one of the messages that I get from staff often is that we...our network is built on HL7 interfaces and the customization that has to go in to make sure that the data coming from one point to the other for each hospital center is incredibly complex. And we actually have developed a gold standard for our implementations to try and make sure that the data is a little more standardized. But managing that many custom interfaces where particular data elements within that HL7 message, making sure they come in and go out in the right order and in the right place is a very difficult task to manage and it adds a lot of work to our process.

Tim Burdick, MD, MSc, FAAFP – Chief Medical Informatics Officer – OCHIN

Hi Carol, this is Tim from OCHIN. On the side that we sit on at OCHIN, I would certainly not want the electronic health record vendor to limit our ability to customize and adjust the EHR in the manner that we need...that we feel we need to customize it. We have been able at OCHIN to innovate in some areas around corrections healthcare, school-based healthcare, and other healthcare services that are a little bit less traditional clinical settings, in large part because EPIC does give us a fair amount of flexibility to create within the system.

Over the past couple of years, EPIC has done a nice job in helping manage the concept unique identifiers behind various different concepts. If OCHIN has a new concept that we want mapped to a data element within EPIC, we can submit that and EPIC will create that and share that across all of the EPIC users across the country. Specifically for purposes like research and healthcare outcomes and some projects that they have done for a couple of research, PBRNs have taken advantage of that work on EPIC's behalf. I think it ends up being a difficulty for OCHIN internally, a governance issue for us to manage our own change control in a way that limits the amount of work we need to do internally. But I wouldn't want that to be imposed by the EHR vendor.

I do think there would be some benefit in having some national standards. If we know that there is an important clinical quality measure that the government has looked at that we believe is going to help Triple Aim, such that the Million Hearts Campaign. It would be great if there were some defined concept unique identifiers that were simplified and could be standardized across the country so that some organizations aren't looking at CPT codes while somebody else is looking at SNOMED and somebody else is using LOINC. Thank you.

Carol Robinson – Principal – Robinson & Associates Consulting

Thanks, Tim.

Carl Dvorak – President – EPIC Systems Corporation

This is Carl Dvorak from EPIC. I will just reinforce what Tim said. Across the country, we have really not seen tailoring of workflows or additional data collection be any kind of impediment to health information exchange and I think in part it is because what we're trying to exchange is standardized and ONC has done a good job with vocabulary data sets and things like that. You will still see people misuse problem lists from time to time, to have it be kind of a social history as well as an actual problem list, but that is pretty rare and not all that painful when it does happen.

Carol Robinson – Principal – Robinson & Associates Consulting

Michelle, are there other questions?

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

There are not.

Carol Robinson – Principal – Robinson & Associates Consulting

Well, I will follow-up then. So my follow-up would be then, in terms of open APIs that create a little bit more of a common level playing field between EHR systems or I guess, common data dictionaries. What else would be helpful in creating interoperability between the EHRs so that when we begin to hook them up for HIEs that they actually can speak to each other and translate information accurately and efficiently?

Carl Dvorak – President – EPIC Systems Corporation

This is Carl I'll jump into that. I don't think APIs or open APIs really have much of anything to do with interoperability in the big picture. I think interoperability is really throttled by the standards, the dictionaries and the rules of the road, at this point in time. APIs are a good thing for local innovation and I know we provide our customers with all of our source code and access to all of our internal APIs as well as a set of published APIs that we guarantee the interface contract for permanent, so that they can build innovations that last. And we also publicly publish some APIs for outside vendors like document imaging, biometric validation of a patient ID or a pharmacist's ID for controlled substances, a wide variety of APIs for third-party devices to send information in. And people use them to great effect, but I don't think those have any real material effect on the interoperability that we are discussing here.

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

Are there any other questions from the workgroup? Carol or Chris, do you have any additional questions for our panelists?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

This is Chris and I have a specific question to Carl. Carl, I am just going to push a little bit and it is okay to push back. One of the things that I am starting to look at is about 50% of new contracts in large or medium-size hospitals is going to EPIC, but the rumor is that about 50% of patients in the nation have at least one piece of information in an EPIC system. Are we moving to interoperability through the means of a monoculture?

Carl Dvorak – President – EPIC Systems Corporation

Oh no, I don't think so. We...like I said, we interoperate with 49 other vendor systems, 20 billion transactions per year go to non-EPIC destinations and come from non-EPIC places. We have more customers with a Cerner lab than we have with an EPIC lab. I don't think we'll ever go there because the voice of the customer will always matter. I do think we will see more and more integration, obviously integrated products can be one vehicle for safety, efficiency and lower cost, much like a car I think. When most of us were kids, you would get a car and you would go down to the car stereo store; they don't even have car stereo stores anymore. The car's stereo as part of the brainstem of the vehicle.

So I think we'll see continued engineering by all the players for integration and we'll continue to see the evolution of well-defined interfaces for them to work together. But I don't for one second see a monolithic vendor and by the way, we are probably arguably the second or third in size so...especially now with the Siemens acquisition by Cerner, we're the underdog still.

Tim Burdick, MD, MSc, FAAFP – Chief Medical Informatics Officer – OCHIN

This is Tim Burdick. As a user of the EPIC product, I can say that I think one reason why there won't be a dominance of any one EHR, at least across the healthcare IT landscape more broadly is that there are going to be smaller organizations at the OCHIN level and startup companies that are going to be innovating in the healthcare IT market much faster than a vendor like EPIC or Cerner or anybody else can. And I believe that for vendors, larger vendors like Cerner and EPIC to continue as a viable organization, they'll recognize that they need to have a certain openness and interoperability with all of the innovation happening around them and that has certainly been our experience.

Henry Wei, MD – Senior Medical Director, Clinical Innovation – Aetna Innovation Labs, Aetna

This is Henry Wei. I'm sorry, I have a panelist question as a follow-up on APIs, if it is okay. Earlier there was a response that APIs are probably not broadly applicable to interoperability. I am very curious as to the panelists in corrections of two different movements, one in the standards domain FHIR, and I think EPIC has commented on this probably before recently in response to the JASON Report. And secondly, proprietary frameworks like Apple's Healthkit and whether or not they are perhaps more important to the consumer-facing application world than the enterprise application world?

Carl Dvorak – President – EPIC Systems Corporation

Well as an electronic health record vendor, we do support FHIR and its emerging standard. I think it will provide really interesting opportunities for people to innovate, probably more early in the field of elegant visualizations, a little bit more in the read domain. I think we are implementing write services with FHIR although I think from a data consistency, data stewardship, you have to closely coordinate with an organization if you are going to be writing data throughout electronic health records. There are a lot of important things there.

And I think we'll have to evolve with things like proper audits, compliance with secondary use of data, accounting for disclosures when that information flows back and forth to an app through FHIR. But we are excited about it and I think as Tim suggested, it does unleash a new level of innovation that we as a health system platform would benefit from. So for us to not support interesting initiatives like that would leave us out in the cold in the long-term, so we're very excited about it and think it will open up a lot of opportunities for innovation.

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

All right. Well thank you, Carl and thank you all of the panelists from Panel 2. We again greatly appreciate you taking the time to share their experience and testimony with us today. I am now going to turn it back to Chris for some closing remarks before we open it up to public comment.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Thank you very much, Michelle. So first of all, I wanted to thank everybody who participated today. I know you are all very busy individuals who have day jobs and we appreciate all the information and thoughts that you had. This is the first of our listening sessions, I think we will take what we have for heard today to heart. I think there are a lot of things for us to follow-up on. And with this, I think Carol you wanted to also say a few things and I'm turning it over to you.

Carol Robinson – Principal – Robinson & Associates Consulting

Thanks so much, Chris. Again, thanks to ONC for making these arrangements and for those arrangements for next week's listening session as well, which will be three-hour session beginning again and 10 A.M. Eastern time. I want to thank the sub-workgroup members as well, reminding both the public listeners on the phone and the workgroup that our task at hand as the subgroup is really around making recommendations to inform a roadmap for interoperability. And secure and safe governance of health information exchange that improves the quantity of health information exchange and the quality of HIE as it moves across the systems.

It is a complex environment; there are misaligned and inconsistent policies in place and that's a natural environment for something as new and as growing as HIE is now in our country. We need to think of this is an iterative process. I think that's something that our workgroup has really, in its early days, really decided upon the roadmap is not a point A to point B and then were done kind of job. It's really we can't...we're not starting where we're starting and moving to a place called nirvana. We will have many stops along the way and we'll need to measure our progress as we reach those stopping points or measuring points. And so, kind of looking at some of the optimistic city or town names across the country, I was thinking of Success, Missouri and Ideal, Georgia. We may not hit nirvana, but I think we have some improvements that we can make.

I encourage the public if you have not had a chance to look at the presentation slides that are posted on healthIT.gov that were presented at this subgroup's first meeting, please take a look at those. And then feel free to submit written comments to this subgroup. We will read them all and take them all to heart. And again, thank you very much we look forward to a robust listening session next week as well.

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

Thank you, Carol. And I just also want to give a shout out to Kim Wilson, who helped us with all the logistics for today's meeting. And with that, I am going to turn it to the operator to open for public comment.

Public Comment

Caitlin Collins – Junior Project Manager – Altarum Institute

If you are listening via your computer speakers, you may dial 1-877-705-6006 and press *1 to be placed in the comment queue. If you are on the phone 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

It looks like we have a public comment from Steve Waldren. Steve, just as a reminder public comment is limited to three minutes. Please go ahead.

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

Thank you very much. I am Steve Waldren and I work for the American Academy of Family Physicians. We represent about 115,000 family physicians, students and residents throughout the US. We appreciate you taking the time to delve into these issues. We have been working on interoperability for a decade and seems that we still need to make a lot more progress.

I want to make two quick comments one on the issues around Direct. I want to make sure that people understand Direct is agnostic to payload and the content standards and a lot of the discussions around the problems with Direct were directed towards some of the issues around the content standards. The Direct Protocol stack allows you to have specific content, but it also allows for any type of content to be sent through the exchange. So, make sure that those are not conflated in the issues that we're struggling with in healthcare.

The other is on the issues of open APIs and I completely disagree with the fact this is not an integral part of what we need to think about as we think about interoperability. Right now when we talk about interoperability, we're still focused in the era of continuity, so being able to move data from one point to the other. What we really need to be able to get to is the notion of collaboration where organizations and providers actually collaborating back and forth. And APIs are really the only way to be able to that; the other, as we look at the Internet and all the great things that we have in the Internet, a lot of those are developed a made possible by use of APIs.

And if we want to continue on the standards front, we know we've been working on it for at least, I know, 10 years on problems, meds, allergies to be able to be making them interoperable and we still have significant challenge. So for us to be able to create some national standards to allow for the completeness of an electronic medical record to move from one place to the other, we're decades away from that. So, these open and APIs allow us to be able to move data, give people access to data and move the locus of control from the vendor to any entrepreneur that wants to innovate and move us forward in regards to interoperability and value in healthcare. We appreciate your time.

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

Thank you, Steve. We also have Michael on the line. Michael, an you please identify your organization as well?

Michelle

My name is Michelle, did you mean to ask me?

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

Oh, we probably copied it wrong. Go ahead.

Michelle Kukrai - Salutopia

My name is Michelle Kukrai and I live in Colorado and I want to take this opportunity to touch base with Morgan and Amy. Both of you obviously work here in Colorado with the HIO and I want to see if I could meet with each of you, I could meet with you as a group. I actually know, the company that I work with is called Salutopia and we have solution for barriers to provide interoperability for this whole discussion that has been taking place. I have been on the phone since 8:00 Denver time, so I've been taking copious notes and I am very, very familiar and invested in interoperability within the HIEs as well as obviously the EHRs and getting the communication barriers broken down. In fact, I have been in contact with the Mid-States Consortium and I have been trying to get in contact with decision-makers so that I in fact, can sit down face-to-face and present the solutions that Salutopia can offer to the HIE industry. And I will mute my phone.

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

Thank you, Michelle. Just a reminder that it's public comment so our speakers do not have to respond, but we can follow-up with you offline. Do we have any other public comments? It looks like that is all. So thank you everyone for joining and we will have our next listening session next Friday at 10 A.M. as

well. So thank you everyone, have a wonderful weekend.

Carl Dvorak – President – EPIC Systems Corporation

Thank you, Michelle.

M

Thank you.

Public Comment Submitted

1. I would suggest that you advise people to do a trial run so they don't sound so rushed at the end - or start with conclusions.
2. Can Carl please clarify "Underdog" comment?

Meeting Attendance		
Name	08/15/14	07/23/14
Anil Jain	X	X
Anjum Khurshid		X
Anne Castro	X	
Barclay Butler	X	
Beth Morrow	X	X
Carol Robinson	X	X
Christoph U. Lehmann	X	X
David Sharp		
Deanna Wise	X	
Elaine Hunolt	X	
Jitin Asnaani	X	X
John Blair	X	X
John Lumpkin	X	
Kate Black	X	X
Kory Mertz	X	X
Mariann Yeager	X	X
Melissa Goldstein	X	X

Tim Pletcher		X
Tony Gilman	X	X
Total Attendees	16	13