



**HIT Policy Committee  
Clinical, Technical, Organizational & Financial Barriers to  
Interoperability Task Force  
Final Transcript  
September 25, 2015**

**Presentation**

**Operator**

All lines are now bridged.

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Interoperability Task Force. 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. I'll now take roll; Paul Tang?

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

Here.

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

Hi, Paul. Bob Robke?

**Bob Robke – Vice President, Interoperability – Cerner**

Here.

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

Hi, Bob. Christine Bechtel? Josh Mandel? Julia Adler-Milstein?

**Julia Adler-Milstein, PhD – Assistant Professor of Information, School of Information; Assistant Professor of Health Management and Policy, School of Public Health – University of Michigan**

Here.

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

Hi, Julia. Larry Wolf?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Here.

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

Hi, Larry. Mike Zaroukian?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Here.

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

Hi, Mike. From ONC do we have Brett Andriesen?

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

Brett is here.

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

Hi, Brett? Karson Mahler?

**Karson Mahler, JD – Policy Analyst, Office of Policy – 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, Karson. And Vaishali Patel?

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – 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**

And Chris Muir?

**Christopher Muir, MPA – Senior Advisor – Office of the National Coordinator for Health Information Technology**

Hi, I'm here.

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

Hi, Chris. Okay, we were getting some bad feedback so somebody I think needs to mute their line. It sounds better now, actually. But with that, I'll turn it back to you, Paul.

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

Thank you very much, Michelle and thank you all for joining the call today. Why don't we advance a few slides please. And next; and here's where we stand. We...last time we went over the feedback from the Policy Committee. Between now and the final report, today we're going to hear about the data update that was presented at the Policy Committee, talk about the information...health information blocking. Last time people asked about the IT Product Complaint tool and then I did some revisions to the recommendations and format to try to accommodate the suggestions from last meeting, and we'll take a look at that. And then I believe the next time, is that correct Michelle that we'll have the summary of our past recommendations?

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

Yeah, we're hoping to have a draft report for next Friday's meeting to review and discuss.

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

Okay. So the com...it'll incorporate sort of the work we did at the beginning of this task force summarizing the previous recommendations so we can put it all in one place; so all of that plus the first draft of the prose. Did I get that right, Michelle?

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

Yup. Exactly.

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

Okay. Next slide, please; so this goes over today's conversation. Next slide, please. And this is just to have in your packet the charge. And next slide, the specific charge about financial barriers and next slide, we'll go on to the ONC data update. Oh, are we going to do...

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

Actually we're going to do the...I flipped the order.

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

Okay.

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

We're going to do the Information Blocking and start with Karson.

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

All righty, thank you.

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

Okay, well thanks so much guys and good morning everyone or I suppose, good afternoon now. So today I'm going to give a brief, and I'll try to keep it very brief, overview of ONC's report on Health Information Blocking which we submitted back in April of this year. The report stems from the same congressional request in The Consolidated and Further Continuing Appropriations Act or...which was the genesis of the task force obviously on barriers to interoperability.

And so given that, we felt that it would be appropriate and useful to kind of present a brief overview of the report to the task force and summarize some of our findings in the report for the group's consideration. I've got about 11 slides here, I think, but I'm only going to cover the first 6, which focus on our findings. The rest of the slides really describe our recommendations in the report, which I'm assuming most folks have read and, you know we know the task force is developing its own recommendations so we weren't focused on that part of the report. If we could go to slide, so I guess the next slide. Okay, great.

So in April we submitted a report to Congress. I guess as background it's worth noting that ONC and the Department had been concerned about this issue of information blocking for some time and as an example of that, if you look back at the 2013 OIG and CMS rules regarding the EHR Donation Safe Harbor under the anti-kickback statute and the Physician Self-Referral Law exception, there was language in there that specifically identified suspect actions of donors or recipients to restrict or limit the interoperability of health IT. So this is something that we've been grappling with for some time. The congressional request gave us an opportunity to approach the issue anew and to really take a comprehensive look at all aspects of the information blocking issue.

So to that end, we spent a good amount of time and energy marshalling and sifting the available evidence. We had extensive discussions with stakeholders, you know we reviewed complaints and I'll go over a little bit of this on the next slide. And then based on that evidence, tried to develop a principled and workable definition of information blocking; and there were many definitions at the time, and there still probably are, and everybody has a different take on this issue.

But we tried to focus on a definition that was principal that focuses narrowly on what we consider to be objectively unreasonable or objectively bad behavior that frankly violates public policy. We don't want to sweep in inadvertent practices and all of the legitimate challenges that folks are grappling with and that impose barriers to interoperability. And so we really tried to be thoughtful and develop a definition that captured the real problem.

We also provided a series of actions that we're taking both at ONC, within HHS and with other federal agencies to try to address information blocking within the scope of our current authorities. However, we also identified some significant gaps in those authorities and our ability to address this problem, which we take very seriously. Let's go to the next slide and the next slide after that; thank you.

So I'm going to talk a little bit about the evidence of information blocking that we looked at, because I think that's probably what this group is most interested in. So in the report we described that in 2014 we received about 60, a little over 60 unsolicited complaints; that's a conservative estimate, and we described in the report what some of those looked like in general terms, some of the trends that we identified.

We also looked at a lot of additional anecdotal evidence, so in contrast to formal complaints we received many additional anecdotes from a variety of industry stakeholders. We had extensive discussions with stakeholders really spanning the entire health IT and healthcare industries. We also looked at public records and testimony. We looked at the available economic research and we relied on our own accumulated knowledge and experience overseeing this industry and being intimately familiar with it for the past decade, since ONC was established in 2004.

I'll give a few examples just to kind of make this more concrete. So in the report we talk about, you know in surveying the complaints, we talk about really I guess sort of three categories of conduct, and this is really where most of the evidence kind of breaks down. So most of the complaints and the information we received involves developers, some involves providers and then some involves kind of I guess a coordination between the two. And we scoped the report in that way; there obviously are other persons and entities that can interfere with the exchange or use of electronic health information, but this is where really we hear the most complaints and where there are the most concerns.

A few examples of complaints that we identified in the report under the developer umbrella found in things like opportunistic pricing. So that would be, for example where we see wide variations in fees for relatively comparable services, which suggests that perhaps developers are engaging in opportunistic practices, a kind of installed base opportunism if you like, charging very high prices for services because they can, not necessarily because that's the cost or the business model that the developer is following.

A variation on that is the refusal to deal, which could manifest itself in a variety of forms. So, you can imagine a developer charging a price so high for an interface or for connectivity or whatever the case may be that really it's deterring a provider or other entity from engaging in the transaction at all. It could also be in the form of a technical limitation or contractual restriction that makes it impractical, infeasible to engage in certain kinds of health information exchange.

Under the provider category, and again this is just kind of a quick overview and there's much more detail in the report so I would encourage folks to look back at that; I'm just giving you kind of some highlights. Under the provider category the concern seems to be, or the most common concern seems to be the issue of health systems and hospitals using health information technology as a weapon, if you like, not to use too strong a term I suppose, but using it as a tool to consolidate markets, to enhance their market position and perhaps their market power.

And that can also manifest itself in a variety of forms; we often hear that certain policies are based on legitimate privacy concerns and security concerns and we certainly appreciate that. But looking at the evidence in its totality and looking at specific complaints and accounts that we are aware of, it seems that there are certainly cases where providers are citing privacy restrictions or other limitations and circumstances where they don't apply. And so this raises serious information blocking concerns from our perspective.

And the third category that I mentioned is a kind of coordination and an alignment of interests between some of these large systems and some developers. And again, of some examples to give a flavor these are generalizations, but this is sort of a theme that emerges from the evidence and that we talk about in the report. And this is the notion that you have a health system or a hospital and it has a vendor and the vendor implements technical or other restrictions or limitations on technology that tend to keep referrals in network, that tend to advance the, you know, tend to keep information both within the developer's technology and network and also within the providers referral network. So those are just kind of some examples to give a flavor. Let's go to the next slide if we can.

So this slide talks about the definition of information blocking, which I talked a little bit about before. And I think it's important to just let me go through this definition a little bit because it does require, I think, a little unpacking. So what is information blocking? There are a lot of different views as to what that means; I'm sure folks on this task force probably have different opinions and different views as to what information blocking is.

But based on the evidence described in our report, we put forward a definition which is shown here and our goal is really to provide a definition that would be neither under-inclusive nor over-inclusive; it would be narrowly tailored, that could be applied in a predictable way. And it would provide clear and practical guidance to stakeholders on the kinds of practices that we believe should be regarded as against public policy and thus, to which the label information blocking should attach.

And we were sensitive to some important policies and values that animate this definition. So there are really three; first we recognize that there are many different reasons why information may be unable to flow and these could be technical challenges, coordination problems, privacy and other legal considerations, a basic lack of incentives. And not every or even most of these actions that impede the flow of information should be characterized as information blocking. We recognize this is a...this is one barrier to interoperability, but it's one of many. It's certainly not the only one; it's a significant one but it's not the only one and that there are many legitimate challenges.

We also recognize that there are often competing interests and so something that we say in the report is that the HITECH Act seeks to promote the secure exchange and use of electronic health information not as an end in itself, but as a means to improving health and health care. And the interest in promoting the free flow of information needs to therefore be balanced against other important interests such as protecting privacy and patient safety as well as legitimate economic interests that spur competition and innovation in technology and health care.

Nevertheless, and this is the third I guess, and most fundamental point that we would make and that has informed this definition; we know that there is a class of actions that seriously do interfere with the interoperability of electronic health information. And that do not reflect these legitimate challenges or advance these countervailing interests that I just mentioned. And in our view, those practices cannot be squared with the basic policy of the HITECH Act and it's these practices that constitute information blocking under this definition.

So if we go to the next slide; this is really just trying to boil down again the definition, which does need to be unpacked. I think you could distill it down to, you know what we're talking about is objectively unreasonable behavior. And so this is really just illustrating that again, there is no litmus test for information blocking. It's a very fact intensive kind of inquiry. One really does need to look at, in any given complaint or allegation of information blocking, all of the facts and circumstances.

You know what is the reason for the conduct? What is the likely impact? Could it have been reasonably avoided? Were there less restrictive alternatives? Is it necessary to comply with the law or with privacy concerns to advance those other countervailing interests that I mentioned? I won't get into all of the theory and everything else, and I think if you look at Appendix A of our report, we go into quite a bit of detail about a number of hypothetical scenarios drawn from the cases, so to speak. And we provide a lot of analysis in there trying to illustrate how these principles apply and how we would look at different types of fact patterns and variations.

And if we go to the next slide; here I've listed the same categories that are in the report, but these are categories of behavior that we feel, for the lack of a better term, are inherently suspect and they break down into these four categories. So, you know if you're looking at contractual or other restrictions on information sharing, especially on individual's access to their protected health information or a provider's ability to access core clinical information for patient care; that is a serious concern to us.

The second category I'd already mentioned before as I was kind of giving some examples of what we have sort of seen from the evidence and that's practices that's found in a kind of opportunistic, you know installed base opportunism. You know, where a vendor is pricing in a way that doesn't really have any connection to, or doesn't appear to have any connection to that vendor's costs of doing business, you know prices vary. Prices may be higher in areas where a vendor has more leverage and so on and so forth.

The third category is the use of non-standard technologies or approaches where standard approaches exist and have been adopted by the Secretary in regulation. And this gets to kind of an issue of gaming the standards, I suppose you could say. And then the fourth category gets to some of those concerns about locking in of users, but also referrals and information within closed networks, providers or vendors trying to consolidate markets, and this blends into other areas of federal law and policy like fraud and abuse and the antitrust laws. That's really, I think, kind of in a nutshell the evidence and the inferences we are drawing from it.

Again, it's, you know, the evidence that we looked at is pretty extensive; there are limitations on it. One limitation is that it's often difficult to really nail down specifics in this area. Part of that is that we talked to a lot of people who are very hesitant to come forward, because they fear retribution, you know, they're worried about contractual terms. We've heard the term gag clause thrown around; it's a bit of an oversimplification, but is a real problem. You know, or part of this is a fundamental lack of transparency in the marketplace that prohibits us from really getting the full, you know, of taking the full measure of how pervasive some of these practices are.

But looking at the evidence in its totality, we have no doubt that this conduct is occurring and that it is a serious problem that needs to be addressed. And I think I'll leave it at that and I suppose open it up to questions. The rest of the slides really go through some of the targeted actions and strategies that we've put forward in the report and I think, unless the task force would like to, you know step through those, I think we can probably just skip to the Q&A, if there is any.

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

Thanks Karson. I think it may be helpful to go over your slide 8, which is targeted actions and the reason is to see if there is anything we would want to consider to include, I mean, a couple of approaches we can actually refer to your report as part of our recommendations or maybe there's one of the targeted actions that, you know rings loud and that we could reinforce perhaps. But why don't you go through slide 8, which is targeted recommendations and then we can ask the group whether there's anything that we should pay special attention to.

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

Sure. Did you want me to step through it, Paul or do you want to...

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

Please.

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

...okay, sure. So this describes some of the...well, this describes really the targeted action. So in the report we described that really we think a comprehensive approach to this issue requires both targeted actions that we can take immediately, we being the government, the administration. But also more comprehensive actions, which really are described more in the Interoperability Roadmap, so looking at the broader barriers to interoperability that I think fall within the larger focus of this group versus the narrower focus of this information blocking report.

So, as far as the targeted actions are concerned, you know we proposed in the 2015 Edition Certification Proposed Rule to strengthen and beef up in-the-field surveillance of health IT, looking at limitations of technology and also developers disclosures about those limitations and additional types of costs which could interfere with the ability of users to implement certified health IT capabilities. So there are sort of two interlocking proposals there; there's the in-the-field surveillance and there's the transparency in disclosure requirements proposals in that rule.

And this really goes to really the ability of providers and of health IT customers to be able to understand what the capabilities and limitations of the technology are in the hopes that this will enhance competition in the marketplace and help create those incentives for developers to improve the interoperability of their technology.

The second bullet point I think it's been discussed at some length, you know the need to constrain standards so that there is less permissible variability in standards and to sort of wherever possible try to make sure that use cases are developed properly and that standards support those use cases and can be implemented in ways that allow for interoperability that don't lead to technical challenges. The fourth bullet point, you know we're talking about governance rules. And so a lot has been said about that in the Interoperability Roadmap.

The fourth and fifth bullet points talk about coordination that we are doing with the Office of Civil Rights to improve stakeholder understanding of the HIPAA standards. So this goes to the issue of, you know, often times providers may feel that HIPAA or say Privacy Law prevents exchange or opens them up to liability or that may not be the case and so we feel that important targeted action is to really work to improve stakeholder understanding of what it is exactly that HIPAA permits and what it prohibits. And largely HIPAA is quite permissive from a treatment, payment, and operations; it really sets a floor that largely enables the exchange of electronic health information. So, we feel education in that area could be very valuable.

On the coordination with the OIG and with CMS, we're talking about the kickback issues, the self-referral issues and really program integrity, which is something that we're looking at. And in a similar vein, I suppose, referring illegal business practices to law enforcement agencies. You know, I should qualify this by saying that most of the conduct that we would consider to be information blocking likely doesn't fall under any current legal prohibition. At the edges, however, there are instances where, you know an entity may be engaging in information blocking and that conduct may also raise a violation of a federal law or a state law.

Actually the state of Connecticut passed a law recently specifically prohibiting information blocking and treating it as an unfair trade practice under state law. So, there are some areas where, you know there are some opportunities for law enforcement and certainly we coordinate with law enforcement agencies, And if we see information blocking or any conduct that raises a colorable violation of the law, we refer that and we work with those agencies to help investigate it.

And then the second to last bullet point on CMS, I mean, this is critical. We also believe that it's extremely important to continue to incentivize interoperability, so I've talked a lot about kind of negative incentives and rooting out information blocking, but ultimately we do need to really change the underlying incentive structures and so we will continue to, and we have been working very hard with CMS to continue to coordinate payment incentives and to leverage market drivers. I've also been working with other agencies to try to create the business case and the incentive structure so that people won't want to block information, they'll want to share it.

And finally, the last bullet point on promoting competition and innovation, you know so much of this...so much of what we see is really a product of a marketplace that is still evolving and that lacks a significant degree of transparency. There are competitive dynamics which often work against information sharing; this ties closely to the payment incentives and things like that. And so, you know an increasing focus for ONC over the last year, the last couple of years really, and we've been working very closely with the FTC in this regard, is finding ways to in our regulations, in our policies to promote constructive competition in the marketplace as a way of driving interoperability. And so that's what that last bullet point is about.

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

Great; thank you. Let me open it up to comments or questions from the group.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Paul, do you want us to use the raise hand function or...

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

Ah, we can try without right now, go ahead.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Okay. So yeah, so Karson that's a great presentation, very helpful. The...my reaction to it as I think about it is these represent some nice ways to both categorize and try to get at it. I'm curious about the 60 unsolicited complaints how they may have been handled or if they couldn't be handled in any formal way because there's not a structure in place, whether you think that what you're describing in the targeted actions would give a practical mechanism for both investigating and resolving the complaints?

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

Yeah, so that's a really good question. So when this came to us, a request from Congress, as you say, you know there wasn't a structured complaint process or anything like that so, we really had to reach deep and across ONC and kind of, you know we collected complaints that we had received and we sort of aggregated those and we did a lot of outreach. Brett is going to talk about a new complaint form resource that we have just put up, which we think will help streamline the process for individuals submitting complaints and other information, not just about information blocking, but about other issues as well.

There are challenges though with how we can or how we have to handle complaints so unfortunately we can't get into the specifics of any individual complaint. We tried in the report to give a good sense of, and I've tried to give you a little bit more detail today, you know a good sense of what we're seeing. But, there are some impediments to us really putting this information out there as much as we might like to. So one reason that we would be very hesitant to do that is that again, a lot of the people who have complained to us or who have shared information with us have been very reluctant to do so because they fear, again, some kind of reprisal.

If they're an employee of a developer, obviously there's potential retaliation there. If they're an employee of a healthcare organization oftentimes the organization has contractual agreements in place, this is pretty much across the board where the organization is expected to enforce the non-disclosure provisions and to discipline employees that run afoul of those. And those can be enforced in a very broad way that can chill reporting and discussion of these problems. So, we want to encourage people to the extent that they're willing to come forward and to report this kind of information to do so. If we publish it, that sort of inhibits our ability to do that.

There's also the basic question of due process and fairness, you know, not every complaint that we receive is necessarily meritorious. I mean, there's a spectrum and even as to those that we feel that we have maybe a pattern of complaints, we feel there's very strong evidence that a particular entity is engaging in these kinds of business practices, we have no way to provide a hearing or opportunity for that entity to respond to those allegations.

We're not a law enforcement agency and so that raises challenges as well. And then there are other legal administrative considerations also prevent us from disclosing complaints. That being said, we are committed to continuing to, as appropriate, make this information known to Congress, to the administration and to provide periodically updates to the public on what we're seeing and the nature and extent of this problem as best as we can discern it.

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

Anyone else? I do notice a couple of things; one is, we'll review our draft recommendations but I think we also are re-emphasizing the need for incentives that would promote the good behavior and hopefully also disincent the bad behavior, but we'll talk about that in just a minute. One thing we could also do is certainly refer in our recommendations to this report and some of the targeted actions that you've recommended. Other comments or questions? Mike, is that your hand again?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Yeah. So just a follow up because I know that report Karson refers to is already out, but it sounds like from what I've heard, some of the things that we might consider sort of like you said, incentives would be one positive force that would help. I'm wondering if there's also a point in discussion of whether there needs to be a whistleblower type protection that will help make it feel safer for people to report.

I heard the value of trying to make sure that if there is going to be investigation of these complaints there needs to be good privacy protection for those who are identified at least until some kind of adjudication is reached. And I also heard that there are no resources available to do that and no enforcement agency that exists so to me, as I hear that commentary, those are some of the things that we might reflect on whether we would want to include that in any kind of recommendations to Congress.

The other part I think I would just add though is the challenge of, for me, the really thorny challenge of trying to demonstrate the difference between what are technical or cost prohibitive challenges versus deliberate attempts to block information. And I think that's going to be one of the really hard things to sort out until we've demonstrated in the field that it's otherwise so easy to interoperate with standards and governance and so on that the only remaining reason is likely to be information blocking.

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

Actually Karson, can you actu...just give round numbers like of the 60 complaints, and one would guess that that's the tip of the iceberg because it's, you know, takes a certain amount of awareness and courage to come forward, I would think; what percent was sort of technical pricing versus more, I mean you had a definition what more obvious information blocking, I mean just philosophically of they didn't want to share? Do you have any kind of way to characterize that?

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

Umm, so it's difficult because again, it's...oftentimes it's a combination of the two and there are other forms of blocking as well. You know, I guess what I would say is certainly pricing is a big slice of it, you know and I think just looking in the report there's a significant discussion of some...there are a number of examples of kind of the types of complaints we have received about pricing. And I should be clear that we're certainly not, the ONC or government trying to suggest that we should be a price-setter or there's a reasonable price or anything else. Developers have different business models and in a competitive marketplace, different pricing structures are great, you know they promote more choice for consumers. So, just wanted to throw that out there in case folks are...

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

Right.

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

...getting worried about talk about what should the price be; but pricing is an issue that we hear over and over again, I'd say probably one of the main issues. Technical issues are also a very significant area where we get a lot of complaints. And then also business practices that may not necessarily be either pricing or technical, but contractual restrictions, policies that make it more difficult to exchange information. An example would be a cancellation of warranty if you want to integrate with a different HISP or a different technology, or things like this which are not pricing practices and they're not technical limitations, they're a business decision, a contractual or a business policy.

Outside those cover, on the vendor side at least, probably most of the types of complaints that we've received those formal sort of unsolicited complaints. There are many other sort of smaller areas where we see issues. And you know, on the provider side, it's often the policies and the policies around the use of the technology and again, to the extent that we get complaints about providers, they often involve competitive considerations, large systems, large hospitals, those kinds of things. So those would be sort of the categories I would break it down into; it's...I don't have any hard numbers for you though, difficult to do that.

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

Larry, you had a question?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, so I'm not sure a question or trying to sort of think this through for myself, but...so, bear with me because I don't for sure know where this is going, but maybe it actually is useful. So in thinking about this, what struck me is that there may be at least three different actors or roles that we've been talking about, right? So a patient might want my information, right. I want my information; a provider is obligated under HIPAA to make it available to me but, you know, the cost of a dollar per page is fine if I just want one or two pages, but if it turns out that they're going to provide me a thousand pages, say this is your record; suddenly it's not very accessible to me.

And I picked that as just a tiny example, I don't know if that's even the most important one. But it's a sense of a patient wanting their information. That a provider wants to receive information from somebody else or they want to send information to somebody else and they're running into barriers of trying to do that. And finally a developer or a vendor might want to connect to another system and they're running into technical or procedural or cost barriers in trying to set up the connection.

And I wonder, as we think about solutions, if in fact these are three very different parts of the story, and they've certainly been talked about a bunch this morning indirectly, but I wonder if they're useful actually to be thinking about framing it in those three ways, about patient, provider and developer/vendor.

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

Well we can certainly think of it, I think what you're adding is the patient side. Karson, was information blocking...well, was information...I don't know that it could be. You mentioned price, Larry, I think actually even in the statute it...there's a term reasonable cost.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

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

And also, HITECH says, I think it's HITECH says that it needs to be provided electronically, if available. So now it's available pretty much in the majority of places now, obviously.

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

I mean, I think there is certainly a patient aspect and I think our Chief Privacy Officer would be very upset with me if I didn't raise the point. So, you know under HIPAA there's a right of access and we feel that a patient should be able to direct their health information, under HIPAA as submitted by HIPAA.

And there's something to be said for if a provider is submitted to send that information, the patient wants them to do so even though it's only a permitted use and the provider does not have to say yes, but perhaps it's worth looking at whether they should say yes and whether it's reasonable, and obviously you have to look at the circumstances. But, is it reasonable to say no to a patient's request to direct their information to whomever they wanted to, to do so.

That's not going to the fee point, but I think that's something that there's a scenario in the report, the FIPPS scenario under the Appendix that kind of explores that issue. So I do think the patient issue is one worth looking at.

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

Okay.

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

I think the other categories you mentioned as well Larry, are certainly...they certainly ring true. There may be other ways to slice and dice it as well, but the idea of kind of trying to separate the...separate out the active and the types of transactions and where the friction is occurring, you know it's an interesting idea; I'd be interested in the task force's thoughts on that.

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

Any other comments either on that or anything else? Okay I think we can keep...we are going to revisit our recommendations and we'll see how we can weave some of this in. So thank you very much, Karson.

**Karson Mahler, JD – Policy Analyst, Office of Policy – Office of the National Coordinator for Health Information Technology**

Thanks so much everyone.

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

And now we'll move on to Vaishali talking about the ONC data update please.

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

We're not quite ready for that.

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

We're not quite ready.

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

Brett is going to do a quick presentation, sorry.

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

Thanks Michelle and thanks Karson for that great background on health information blocking. Just wanted to spend a couple of minutes here giving folks an overview of our new Health IT Complaint Form online, if we can go to the next slide.

Karson talked about trying to pull together a lot of the different comments or complaints or different...of information blocking that we heard really has raised an issue internally inside ONC that...need to have a better way for us to better track the information that we are receiving from stakeholders across the country about the challenges they're experiencing with their health IT. That exercise that he described really involved kind of a lot of different staff looking through their inboxes at different e-mails they had received from stakeholders or different conversations they may have had, various phone calls.

And so we really designed four of us of different offices of ONC designed a centralized office by which we can receive complaints or issues that stakeholders are having with IT products. And it really gives us a one-stop shop to really look and say, by running a simple report say what are the different issues that we have seen come up about usability or about health information blocking in place without having to kind of ask different folks across the organization.

Really it helps improve our processes internally, it gives us greater situational awareness of the challenges and it definitely creates operation efficiencies on our side. And for stakeholders it ensures timeliness and consistency of responses to stakeholder concerns as everything is routed to correct staff versus just to the person that someone may have e-mailed that their...we can move on to the next slide.

Apology for the ambulance...by in the background here. So the form itself, you can see the link there at [healthIT.gov/healthITcomplaints](http://healthIT.gov/healthITcomplaints). It's live now if folks want to go check it out. It really is there again as a central way to allow for submission of complaints or concerns related to health IT certification, related to information blocking, health IT safety, usability, privacy and security. Complaints related to clinical quality measures and then we also have an "other" category if folks aren't quite sure where that fits and just want to send information to us.

As I mentioned, complaints are then routed from this online submission form to appropriate ONC subject matter experts that really understand the issues of the complaints pretty well. And I will mention that stakeholders do have an option to remain anonymous if they would like to, which does get at some of Karson's mention about, you know, potentially people feeling uncomfortable contacting ONC because they don't want to be named.

So if we move on to the next slide; so again, once complaints are submitted, the appropriate ONC staff will receive the complaints; and all of them are read. We do make a note here that not all complaints may be responded to, just because we might receive a lot of different things, we may have different processes on our end at how we need to track those or to attempt to get resolution to those. Where folks have chosen to provide their contact information to us, ONC staff will contact those folks if there's more information needed to resolve or to research the issue further. If necessary, the staff may refer matters to other agencies including law enforcement agencies or our close...at CMS or various other parts of the administration to help resolve those...those complaints. And then information, as I mentioned, that's received does help us provide situational awareness on the breadth and depth of issues across the industry.

So that's a real high-level update. I think my next slide just has my e-mail address in case folks do have additional questions about the form and I'm happy to field any questions now, before I have to jump off here.

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

Thanks, Brett. One question is, Karson talked about some of the fears of reprisals, etcetera and potential contractual restrictions, those kinds of things. Do you ha...how have you thought about that in terms of people being able to report? I guess one of the ways is just report anonymously, that's sort of the out or are there other kinds of protections or confidentiality provisions that you've thought about there?

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

Specifically related to information blocking, I can...I might send that over to Karson to let him answer but yeah, one of the reasons we did choose to allow folks to remain anonymous was for that exact reason. And because there are some concerns that stakeholders may have if they're submitting complaints about confidentiality of information, that's one of the big reasons why we're not really able to share different numbers or different types or different complaints related to specific vendors.

We try to keep everything that we're receiving for our eyes only really, unless we need to share with other agencies rather than kind of publishing those publically, so folks don't have to feel like they may be in violation of their contract and would be posted publically somewhere. We don't want anyone to feel that way; we want to make them feel that they're able to submit those complaints to us to help us help them in getting some resolution.

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

All right; thank you. Other comments or questions? I don't remember, is Christine on the call?

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

She's not here today.

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

She's not here, okay.

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

It looks like Larry might have a question.

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

Okay, Larry?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sure. So Brett, could you comment, this has been out for about a week now, right? Could you comment on any kind of response you're getting, either sort of general comments in the press or actual people using the site and beginning to report stuff?

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

So in terms of...I do know that we have received some press; at first there was some...a little bit of negative press just related to an initial snafu on our launch, but we have received additional press now about getting the word out and trying to help folks realize that this resource is here and available to them.

In terms of what we've received thus far, I think it's a little premature to be able to provide statistics on the number and the specific types of issues. I do know that we have been getting some traffic there and folks have been submitting complaints and those are starting to get routed to the appropriate folks within ONC to take a look and see if there's more information needed. It does take a little bit of reconciliation because we don't want to report that there's "X" number of complaints and realize that more than half of them were duplicates like someone had submitted a couple of times. So, we're not able to give that information at this point but I do know that there's been a fair number that have come in; I don't know the exact number though at this point.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, I was mostly looking for something general, like what you said. I wasn't expecting that there's, you know, you say we've had a thousand substantive submissions in the last week, I would have been shocked, but...

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

No, I think it's a much lower number than that, it's definitely in the double digits.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, great. Thanks.

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

All righty, well thank you to Karson and Brett for their updates; clearly it's a serious issue and we do appreciate from our last call that there's some ability to receive more information so we can learn more about both the prevalence and potentially general actions to try to mitigate any of the negative effects. So thank you for that. Now we'll move on to Vaishali, right, for ONC data updates?

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

That's right. Thanks. So today I'll be...maybe we could just move to the next slide in the interest of time. I will be talking about the draft interoperability measurement framework and describing proposed measures to assess progress related to interoperability in both the near-term and the long-term and discussing next steps for implementing the framework and the proposed measures over the course of the near-term and long-term. Next slide, please.

So I'll be going into the draft interoperability measurement framework and next slide. So before I talk specifically about a framework and set of measures, I did want to set a bit of context. And this is an infographic that was developed to describe the Interoperability Roadmap and it's, you know, there's a recognition that, you know, the path to interoperability is a journey and we want to measure progress along that journey and we've set goals in the 3, 6 and 10-year timeframe. And the measurements correspond to those specific goals and milestones.

So, along the 3-year timeframe we're hoping that a majority of providers and individuals will be able to send, find, receive and use essential health information. Across the 6-year timeframe we want to begin seeing impacts on quality and outcomes and also expand usage across non-healthcare settings, looking at interoperability across non-healthcare settings and then in the 10 year horizon, really looking at the role of interoperability in supporting the learning health system. And our measurement strategy and set of measures that we're proposing really try to align with these goals and with these timeframes. Next slide, please.

So in the near-term, so over the course of this, you know, next 3-year horizon, which actually ends in 2017 uh, which is not too far away, the focus is to measure our progress as it relates to the movement of electronic health information and specifically across the following settings; hospitals, physicians, behavioral health and LTPAC providers; so providers along the care continuum as well as individuals to assess whether a majority of them are able to send, receive, find and use key health information. And also to assess barriers to interoperability so we understand why we're seeing the patterns that we're seeing with regards to interoperability.

And then in the near-term, we also want to examine not just that information is flowing and moving, that information is exchanging in an interoperable manner, but that it has...having some impact on the availability of information. So looking at the extent to which electronic health information from outside sources is routinely available where and when it's needed, particularly at the point of care and also assessing whether this increased availability of information is helping address gaps in information exchange that might be experienced by individuals, either amongst their healthcare providers or between their healthcare providers and themselves.

And finally, looking at the extent to which the availability of information is leading to increased use of that information. So looking at the extent to which electronic health information from outside sources is routinely used for decision-making and managing care. So to what extent is information that is being exchanged in an interoperable manner, to what extent is that changing decisions, influencing decisions and being used downstream? Next slide, please.

So in terms of the specific measures, you know overall the types of measures that we are interested in is looking at the proportion of individuals and providers along the care continuum, so office-based physicians, hospitals, behavioral healthcare providers, long-term care and post-acute care providers that are sending, receiving, finding and using electronic health information. So are they exchanging in an interoperable manner? And does that lead to having information available from those outside sources at the point of care and to what extent is that information then subsequently used to inform decision-making?

And in addition to these measures that assess interoperability and the extent to which interoperability is occurring, we want to understand whether, you know, if it's not occurring, why it's not occurring. And so assessing barriers is important. And this is an area where, you know I would say that we would really welcome some suggestions on data sources that we should be examining to measure barriers to exchange. And you know, in August I had presented to this task force on barriers to exchanging interoperability as reported by hospitals, based on a national survey that we had conducted in conjunction with the American Hospital Association. And we would welcome input on the types of barriers that we should be measuring as well as looking at other additional data sources that we should be considering with regards to measuring barriers to interoperability. So we'd welcome suggestions on that...in particular. Next slide, please.

With regards to next steps, so for the near-term we're planning on reporting on progress based on our current data sources and these include national survey data related to physicians, hospitals, you know, the one I mentioned the American Hospital Association survey, as well as we have national survey of consumers that we regularly conduct as well. And we also have Meaningful Use attestation data that we can leverage, but we do recognize that there are limitations to these data sources and we are trying to work with stakeholders and federal partners to refine measures and the data sources that we have, expand on the data sources that we have as well as address gaps.

So, shifting from survey data, or at least, you know gathering complementary data that are based on system usage rather than self-reported data, expanding the scope of measurement to include behavioral health and LTPAC. So working with CMS and SAMHSA on these fronts, as well as taking our own efforts in these areas and then partnering with external stakeholders and SDOs on adoption and uptake of standards. Next slide, please.

So beyond the near-term, as I had mentioned when I was...when we were looking at the infographic that, you know in the near-term the focus is on sending, receiving, finding and using information across the care continuum and individuals. Well, across, you know in the long-term measurement, you know beyond 2017, we really want to expand this...expand...our goals expand to looking at non-healthcare settings. So therefore our measurement also will expand beyond the settings, the traditional sort of healthcare settings to looking at settings that are outside of the traditional healthcare settings, so looking at public health, EMS and first responders for example; also looking at non-healthcare settings so schools and social services.

And, you know, as we think about the 10-year horizon, the learning health system, also thinking about research consortiums, for example; so again, expanding the settings. In addition, if we look at the right-hand side of this graphic, we want to expand our measurement to look at not only impacts on near-term indicators such as like availability of information and whether information from outside sources is actually used for decision-making, but also assessing impacts on processes that are enabled by interoperability across the settings and populations of interest, as well as the downstream impacts on outcomes that are sensitive to interoperability. That might relate to patient safety, increasing adherence to evidence-based care, healthcare utilization reducing redundant testing for example; things along those lines. Next slide, please.

So the next steps with regards to the long-term measurement strategy are to, you know we're already in the process of engaging with federal partners and stakeholders to really expand the scope of measurement outside of the care continuum and individuals. So for example, we are working with ASPE on the contract that they have to support the development of interoperability measures for providers and entities that are outside of traditional healthcare settings and for developing measures that might be specific to patient-generated data. So again, just we're beginning to engage in this work of thinking outside of the...outside of our immediate scope of providers along the care continuum and thinking about who we need to partner with to begin measurement in these other domains.

In addition, when we're thinking about measuring impacts of interoperability on outcomes, we think that that needs to be developed in a comprehensive manner as part of a comprehensive measurement framework, which will identify downstream impacts of interoperability using a really validated, external stakeholder-driven process, similar to an NQF type process. So we're in the process of beginning to engage in that as well. Next slide, please.

So to summarize, in the near-term the interoperability measurements, so up to 2017 we're really focused on measuring interoperability in terms of sending, receiving, finding and using of electronic health information across the care continua and individuals. We're focusing on assessing the near-term impacts of that on the availability of information from outside sources and the subsequent usage of that information to inform decision-making and also assessing barriers that might impede interoperability.

And then in the long-term, we want to expand measurement of interoperability to settings beyond just traditional healthcare settings. And we also want to assess the impacts of interoperability on key processes and outcomes that are sensitive to interoperability. And next slide. So I'd be happy to take any questions that you may have at this time. Thank you.

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

Okay. Thank you, Vaishali. Questions or comments? When do you think you might actually have some draft measures to...were you planning to sort of propose some things for public comment as well or what's the actual process of getting those measures and when do you think they would be available?

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

So I think for the...we have like sort of an ongoing process I would say, as I you know, described with regards to the near-term versus the long-term. You know we've already begun reporting out on the baseline estimates as it relates to interoperability. So for example, the presentation that I had done in August as it relates to hospitals and hospital settings. We reported out on the proportion of hospitals that are currently sending data, receiving data, able to incorporate data and are...have subsequently information available at the point of care from outside sources.

So we're beginning to report out on some of these statistics across these settings. It is in a bit of a...the timeframe on that is not quite as synchronized as ideally we would like because the physician survey, you know was in the field, you know...will be in the field in...is in 2015 and so we'll get the data some time in 2016, so you know, there's data lags because of just the timing and the data collection varies. But...so that's, you know, we are in the process of trying to report out on these measures that I just discussed.

And in terms of the development of the more long-term measures, you know, I don't have a specific timeframe that I can sort of report off the top of my head. But we are trying to accelerate the development of these...even these more longer term measures and...because we know we need these for example for MACRA reporting and other congressional requirements as well. So, they are high priority and we are aggressively working on these.

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

Okay, thank you. Mike?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Yeah, thanks Paul. You may have just partially answered my...one of my questions; I have two. But one is the issues of with the long-term measurement goals and settings beyond healthcare...

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

Um hmm.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

...whether additional policy levers, whether incentives or regulation or others are going to be needed to help not only make it possible to interoperate but actually see the interoperation happen, the exchange happen and end up being used in productive ways.

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

That I will, umm, yeah I'm more of a measurement person within ONC so, you know, I think you know, you make a fair point and that's something that probably someone else within ONC would probably better comment on, in terms of the role of you know incentives in accelerating exchange, particularly across these settings that are, you know not necessarily under the purview of, for example, Meaningful Use Programs and things like that, right now.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Okay, yeah, I appreciate it and actually it may be an area for us to be creative in some of our comments about, so thanks for that. The other one though is, as you were speaking I couldn't help think about sort of the halo effect, the notion of how is it that both the availability and ingestion if you will or...

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

Um hmm.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

...use of the data might be promoted by expanding halo effects such as the external practice that just did smoking status and counseling or something related to a quality measure because you accessed it because you've ingested it into your system, you too, if you will, can get credit on or report that, even though it may not have been primarily done by your facility itself. Any thoughts to that?

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

Oh, so, okay, just to make sure I'm understanding; you're talking about when someone ingests data from an outside source and that outside provider had say, you know performed a particular quality measure whether...who gets credit for it, is that what you're...

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

To having it count more broadly because if we think about care teams as not being within the confines of a practice...

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

Um hmm.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

...and we start to think about a community of care and avoiding duplication and redundancy and the like, to be able to say, well there are intrinsic rewards that come from that but there's also external recognition of the value of using...accessing, using and ingesting those data and that if you have trusted partners on a care team outside your system that are doing that, you too should be able to report that as part of your measures and oh, by the way, if you can demonstrate ways where that information came from, you're actually proving some of the interoperability that's happening and helping to encourage additional innovation and use of that within systems.

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

No, I mean I think that's a good suggestion and I guess something for us to think about when we're crafting measures of interoperability, thinking about the broader care team and trying to measure information that's coming from outside sources to support shared de...you know, decision-making across the care team.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Thank you.

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

Okay, anything else? All right, thank you very much, Vaishali.

**Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology**

Thank you.

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

And could we go to...back to our...my slides, please; and we'll go to slide 9, yeah. Uhh, we may be off. Okay, that's perfect. So what I've done here is to revise and reformat really our recommendations so far and I'd like to review this and get comments back on this and whether we want to take into account any of the information we just heard today.

So I've actually reformatted into four different points, just to make sure each point gets good weighting. The first has to do with multi-stakeholder action; this is our call to convene this group to kick-off the efforts. The background is we heard that the landscape has changed dramatically, EHRs are...the data's out there, the market is moving we heard in the right direction, but we...but the agreement from the...the consensus was that the pace is not fast enough to meet our needs to shift our payment model over to a pay for value. And that people were not moving, partly people are not moving fast enough because the financial incentives were not palpable enough.

The complication...a complication for interoperability is you have to have, it's just like FAX, you have to have both the sending and receiving. So you have to have collective action by a broad group of stakeholders and it has to be done in synchrony. So this makes it challenging.

So because we thought that we needed sort of a big push, and involving other stakeholders who may not even know that they're, you know currently we depend on them, our recommendation is that we convene a major stakeholder initiative co-led by the federal government and private sector to act on the ONC roadmap that we'll hear the final...we're expecting to hear the final of in our October meeting to accelerate the pace. So the pace...the movement's in the right direction but we need to accelerate.

So the rationale; so the federal government plays an important role in both convening and in spurring collective action. The private sector's required because really the business interest is what will keep it sustained and have it materialize. So without a specific char...without a specific game plan with responsibilities, roles and timelines that we don't think the action on the roadmap will occur fast enough.

So the purpose of this convening working summit is to enumerate, define and set the timelines for the various actors, hopefully get their buy-in, which is why we're asking for high level representatives from each of the stakeholder groups. And creating the palpable, compelling business model and that would...we'd be calling upon the payers, both public and private. That was the background and the restatement of recommendation one. Next slide, please.

The second one has to deal with measures, the HIE-sensitive outcomes measures. So the background is that we have performance measures that really are not being used well enough, they're not meaningful enough either to the providers who produce the services or the consumers needing to choose. And so we called on the measures that matter to both the consumers and the providers to help make choices of providers and health plans by consumers, by individuals. And that providers would also appreciate clear, actionable measures so that they can both assess where they are and improve them as they form these alternative payment model.

The traditional...our observation is that the traditional measure development process and participants aren't creating the measures that really are needed to move, as we move the payment systems from a transactional fee-for-service into the outcomes-oriented type. Our recommendation was that not only that we do need new measures, so therefore we need to develop and implement meaningful measures of HIE-sensitive outcomes to be used in public reporting and payment. And that since they don't or not...and certainly not in large volumes do not currently exist, that there needs to be a funding mechanism developed. And that may be both a combination of public and private.

We certainly know that CMS funds some measures; that they would be targeting coordination of care, affordable care and we gave an example of no reimbursement for medically unnecessary duplicate orders that would help both coordinated care and affordable care. So that isn't necessarily a measure, but it certainly has a lot of the attributes that we're seeking.

And the rationale behind this recommendation is that we have the traditional measure developer and measure development process aren't generating the measures that really matter and that are needed in the new world at a quick enough pace. So we believe that there needs to be the funding of this and the quick pipeline into the endorsement. Next slide, please.

So we're separating...this was one of the suggestions on our last call, the measure for HIE-sensitive outcomes from measures of vendor performance. And the background is that we feel the effects of a lack of H...health information exchange but we don't have a transparent way of seeing where the bottlenecks are, so we were as...and that would both inform the market, inform the oversight and inform providers. So we needed some way of both seeing what's going on now and seeing that it continues the difference between the one-time certification and the ongoing surveillance.

So that's why we recommended both the development and the implementation of HIE-sensitive vendor performance measures; again, that would be publically reported. That would have to be...that...those measures would have to be...the development of those measures would have to be funded. We gave an example set which relies not just on numbers of external data exchange, that's the denominator, but goes all the way to, and it was referred to by an earlier presentation, actually Vaishali's, that we wanted to make sure it got in the hands of the people that need it and was actually used. So in this example, you'd have to go all the way to the fourth bullet point to know that by exchanging information we're having an impact on care.

The rationale is that the certification process itself is not transparent, that one-time certification doesn't necessarily predict, and that was some of the complaints that were heard, that it actually is put in use in a practical way, meaning a non-high cost way. And that is actually...so we're saying that we don't have a number in these measures to see where we are and to have a continuous improvement in availability and the use of HIE. Next slide, please.

And the fourth one, this was called out as the fourth one to emphasize it, this was the point that we made last call as well in that people are saying over and over again that yeah we get where the market's going, but we just really aren't pressed to do that right now. That is the lack of palpable financial imperative, which really drives the business model. So our recommendation is that payers do incorporate HIE-sensitive criteria as they design their new payment criteria. And that the timeline be set so that people know where the pack is going and have a chance to develop tests and endorse those measures and incorporate it in systems.

But that it is so clear that it gives a much more palpable credibility to the fact that the world is changing, this is the way it's going and everybody has to collaboratively get to there. And some of these measures would be in the domains of reaching health outcomes at the community level, having high quality coordinated care and, as we just mentioned actually, the coordination across both the health and the social services continuum.

And the rationale is that pay by...pay per value is broad, you can't do this without interoperability, it requires this collective action and it would be good if we had specific objectives to work towards. It's not that it would be comprehensive out of the gate, but if we knew exactly, we meaning collectively all the stakeholders actually have to participate, you know exactly what was going to be measured, that would help move people, at least on concrete projects to arrive at that destination.

So those are the four...the way sort of rewritten those four and incorporating the comments, the feedback and the clarity and the specificity we talked about last time and the importance of the payment incentives, the palpable payment incentives to move this at a faster pace. So let me open it up to comments on this sort of revision of...thoughts...Larry?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So this is maybe more a housekeeping question: It looks like recommendation two and three have the wrong heading on the slide and I'm wondering if actual the provider one got lost in the splitting out, because it looks like slide 2 is talking about consu...the heading talks about consumer, most of the content talks about consumer and recommendation 3 mostly talks about vendors, but the heading says provider.

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

Okay, yeah, it should be...with a vend...it's almost about vendors; we can certainly change that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Is that right? Do I...am I reading that right?

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

You're just saying that it really, and I noticed that before it got posted it should be like about senders. Any other com...what about, do you like the way that...do you like these four recommendations, so there's a separation to try to provide emphasis? Do you feel there's an appropriate emphasis on the payment incentive? Let me stop there. Mike?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Yeah, so first, yes I do like it; I think it's a great overall structure. I had a couple of suggestions that might help...

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

Um hmm.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

...but I'd like to see what you think. So one of the things I've been thinking about is that notion of the...on draft recommendation, what is it, 3, where we're trying to measure the transparent measures of performance and we're looking at things like orders changed. As I think about what would be good evidence that the fact that I retrieved, reviewed and acted on the information, and somewhat related to my comments to Vaishali that notion that, we know that if somehow you change your orders in process or existing orders that may be informed by a change that a specialist may have made, that might imply it.

The other thing I think might be a use case that would pertain to a lot of primary care physicians like me is that before I make my decisions, before I enter my orders, I'm actually retrieving and reviewing information as part of the office visit, whether in advance as part of the encounter or during the encounter and then doing orders. That might be another measure of, if you will, the timing of retrieval and review and the closing of the encounter or order entry. So that's just one thought.

The other one relates to coordination of care, I think it's in the recommendation 4. So if we're looking at sort of payment incentives for evidence of coordinated care, I guess I'm wondering a little bit of what we mean by...what will the evidence be of coordination? What actions on sending, receiving, reviewing or acting on exchanged date should mean to payment incentives? So I think those who like to get paid for doing work, separating adding value, if we believe that that process of receiving, reviewing and taking action on that has value, then should we have a mechanism, if you will, that says people who go through that work we're betting is going to improve care.

So the ability to build in an incentive that includes sort of what the workflow of this kind of review means to care coordination and having a mechanism to create incentive payments that relate to that would be a good thing to think through, I think. It would encourage it in the world that I see.

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

I think that's act...that's very true. Do you have a suggestion for how we would measure that besides the check-off kind of measures...if you click on it there are a number of...or there could be educational things where you're required to click on things and people...it's sort of another version of a checklist. How should we measure that in a non-intrusive and non-gaming, non-checklist, burdensome kind of way?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Yeah...

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

We're really trying to see, was it used and so obviously the example of orders changed midstream because you got this alert or something; how could you do that, yeah?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Yeah, so just trying to take an example you and I might both be familiar with in our EMRs. So there is this opportunity to...we get reminded if there's outside information that may need to be reviewed. Clearly our technology could indicate whether we did or didn't do that. Our technology could also say whether we retrieved information from another source where a patient was and that as part of our encounter we reviewed that information or didn't or retrieved additional information or didn't.

So I think at least within some vendors there may already be some auditing type of processes that can be tied with the encounter that say, if you did...if you have the ability to report that these things happened during the encounter, that's part of what we would count as the care coordination, because that's clearly an effort to try to tie together what's happened elsewhere in the process of delivering care.

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

Right, right.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

So, just one idea.

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

Okay. Umm, Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well, I think these are related things; I'm thinking about where Kindred is being asked to participate in some kind of care coordination or we're looking to take on some kind of care coordination and the thing that seems to be at the top of everybody's list is notification that care is being provided. So a patient showed up here and we're doing something or consult was requested and maybe doesn't require patient shows up, but patient data shows up, maybe images or maybe path reports or something that's going to get interpreted and then some kind of report back, action...is going to happen; so just a notification that a provider is in the loop.

So traditionally this is someone publishes and admit, discharge or encounter information out a network and it's either to an ACO or to a Health Information Exchange or to some clearinghouse that's acting to pass along notifications based on membership lists and...of different kinds. So, I don't know where that gets captured, but it seems like it's a really fundamental piece of care coordination happening is knowing that care has been provided and perhaps as well, being able to access a list of who are the care team members who have actually engaged this patient; so other settings in which care has happened. So that's one...

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

Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

...thoughts on things that could be measured. Umm, a second one is...

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

Okay...

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

...go ahead, sorry Paul.

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

No, go ahead; I didn't know that you weren't finished.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So a second piece is, and we were talking about this in some of the stuff is the data that drives clinical decision support, right? So I'm now looking to do something, umm either someone's reviewed it and they as a human being see something and they change what they're doing or the system says, oh hey, you know, I've got a BUN from some prior setting and it suggests you want to adjust the dose of this drug. So there might be this integration with clinical decision support and depending on, I'm really jumping ahead a few years in our current capabilities, assuming we could track data provenance and that the clinical decision support tools were tracking that as well and that when they trigger, they could be looking at where the data came from; so a long road from here to there perhaps.

A third area would be patient data that feeds outcome measures. So I saw somebody, they were in my care over a series of days or weeks or months and I did some assessments at various points in that care and that assessment data that I collected maybe could be used to look at improvements in their functional status, improvements in how they get through their day so that there is some underlying data that's being collected and that that is driving some kind of e-Measure and that that information can get passed along from setting to setting, so we could actually develop a longitudinal view of patient condition improving or deteriorating.

And the fourth area are things around shared care plans. And so I realize these are sort of in some ways very specific kinds of things, but they seem like they fall into this area of things where its feeding some of the emerging payment models and also might improve the ability of an individual provider to do a better job of their piece of coordinating care.

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

Okay, thank you. Anyone else?

**Bob Robke – Vice President, Interoperability – Cerner**

Hey Paul, this is Bob Robke...

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

Christine are you on? Okay, hi Bob.

**Bob Robke – Vice President, Interoperability – Cerner**

A quick comment on the safety, I think it's the fourth recommendation. I was curious on part of safety actually from an organization standpoint is really risk or part of its considered risk and I don't know if the folks on the phone are following on the financial industry and the shift...the risk shift that's occurring here in October of moving the risk of credit card fraud from the banks to the retailers. And the reason why they're doing that is to promote the retailers or to incent the retailers to implement higher...the banks and the retailers to implement the higher level of security with smart cards, and we've probably all been getting those in the mail recently.

And I'm curious if there's any legs of that kind of concept with safety; for instance, a safety event where a patient is...there is an adverse outcome because of a lack of information. The risk of that or the risks or the responsibility of who is to provide that information or who is to accept it; is there...do you think there's anything there from the healthcare standpoint that could drive or incentivize folks to push some of this technology? It's more of a question; I just thought that was an interesting way to promote technology where there wasn't an incentive in the retailers because the banks were always at risk for the fraud? Now that's moving away and the individual companies that have the least amount of technology are the ones that are liable for that credit card fraud.

I just thought it was interesting in that what we're doing here if that has any correlation with what we're trying to accomplish.

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

So the banks are liable for the fraud, right?

**Bob Robke – Vice President, Interoperability – Cerner**

As of October 1, whoever has the least amount of technology is responsible for the fraud, whether it's a retailer or the bank. It's a new rule and I'm not sure if it is a law or how it got established, but as of October 1, if you have...if you walk into Target with a Smart Card, credit card and they don't have the appropriate technology to use it and there's a credit card fraud, then Target's on the hook for the dollars, not the bank. So I just thought it was interesting that they...that the banks could not incentivize the retailers to do anything because the...in the past because there was no incentive for them because the banks were always on the hook for the fraud; now it's...

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

Right, right...

**Bob Robke – Vice President, Interoperability – Cerner**

...shift of...the shift of risk has gone to who has the least amount of technology is who's at risk.

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

It can be pretty complicated to...

**Bob Robke – Vice President, Interoperability – Cerner**

It would be very complicated in healthcare, but I'm just throwing that out there, that is an overnight change that has moved a whole industry in less than 9 months.

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

That's interesting. Let me start off...tie in, let's see what people think about tying in the whole information blocking we heard about earlier in this call and one possibility, and one of the things that was one of their target actions was to in some way tie payment, CMS policies to information blocking; that is, find a way either to incent good behavior. So you could imagine that this whole example of no payment for medically unnecessary duplicate would be, well I suppose that is on the...side, but things like that would...so on the plus side, it would incent information sharing, appropriate information sharing. Any...should we make that statement because that example we have under recommendation under three, should we make the statement in our it's already a payment incentive in recommendation four about working to prohibit information blocking? And I understand there's a whole bunch of definition that would have to occur there, but should we make sure that that's not missed in our recommendations?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

So Paul, this is Mike; I would certainly agree with the inclusion of it. I'm trying to brainstorm a little of how to turn it into something practicable that is similar to an area where we currently work. So, having heard their concerns about privacy and security and what does HIPAA allow and the like, and then thinking about my own organization's rigor with which it does its own privacy and security analysis and their compliance rules and all those sorts of things.

If I were stuck trying to figure out a way to ensure this on my own end, I'd probably use my organization's same compliance group to add interoperability to privacy, security and exchange of information. And use the principles that I heard in Karson's presentation to then do sort of a survey and analysis of what are our policies, procedures; what are the vendor capabilities, etcetera, etcetera and report out on gaps and what we need to do to close them, whether it's lab test ordering or referrals openness or whatever it is. No idea what the unintended consequences of that are, but trying to think of a way to move forward on it, that's one strategy that comes to mind.

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

That's sort of interesting, it's...you're trying to educate folks who might be over-zealous and inadvertently block sharing to say, hey look, let's do this. Just like we look at innovation and regulation and try to have that...find that right balance; same thing, the permission versus the need for sharing in order to improve care...that tightrope.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Right, and at least within our organization, that's a trusted entity that gives people permission, lets them know what they can and can't do and what they must or must not do. So they already have the opinion, leadership and credibility to be able to say, you know as an organization we really need to do this and oh, by the way, it's okay to do that.

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

Right, right. Okay. Is Julia still on?

**Julia Adler-Milstein, PhD – Assistant Professor of Information, School of Information; Assistant Professor of Health Management and Policy, School of Public Health – University of Michigan**

I am.

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

I know that you had advocated for let's say recommendation four; how does that look to you?

**Julia Adler-Milstein, PhD – Assistant Professor of Information, School of Information; Assistant Professor of Health Management and Policy, School of Public Health – University of Michigan**

Yeah, I think it looks good. I think it sort of ties it all together much more cleanly and makes it clear that we're proposing the measures and then sort of paying for those measures.

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

Right. Okay. Any other comments on these four recommendations or the way that it is presented? What we're going to do is we're going to translate this into prose and that hopefully you'll see a draft of that next time, right Michelle?

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

Yes.

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

Okay. Any last comments on that? Great, thank you. Now we'll open up to public comment, please.

**Public Comment**

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

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

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

While we wait for public comment, we did receive a comment via the public chat from David Tao. His comment is I commend the task force and Vaishali Patel's emphasis on developing meaningful interoperability measures. I hope that the measurements will help but that they won't generate unintended consequences such as incentivizing maximization of measurements at the expense of usability. More is not necessarily better; I encourage an emphasis on quality, usefulness and outcomes more than on volume. For example, if someone were to send every transitions of care document to everyone on a patient's care team, that might be wasteful. Or if query were to become universally available to all providers, someone might feel overwhelmed deciding how many queries to send. I think the task force recognizes these challenges, and I just would like to reinforce usefulness and usability considerations in designing the measures.

And we'll also send that around via e-mail to the group and it looks like we have no public comment.

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

All right, thank you everyone for participating and I think we have some actionable recommendations coming out of this workgroup. We're going to summarize our comments on the past recommendations surrounding interoperability from all of our efforts...before and in a prose document that we'll review on the next call. Thank you.

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

Thank you, Paul. Have a wonderful weekend everyone.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Thank you, Paul.

**Julia Adler-Milstein, PhD – Assistant Professor of Information, School of Information; Assistant Professor of Health Management and Policy, School of Public Health – University of Michigan**

Thanks.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System**

Take care.

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

Bye, bye.

**Public Comment Received During the Meeting**

1. David Tao (ICSA Labs): PUBLIC COMMENT (I don't have to say it on the phone): I commend the ITF's and Vaishali Patel's emphasis on developing meaningful interoperability measures. I hope that the measurements will help but that they won't generate unintended consequences, such as incentivizing maximization of measurements at the expense of usability. MORE is not necessarily better. I encourage an emphasis on quality, usefulness, and outcomes, more than on volume. For example, if someone were to send every transition of care document to everyone on a patient's care team, that might be wasteful. Or if query were to become universally available to all providers, someone might feel overwhelmed deciding how many queries to send. I think the ITF recognizes these challenges, and I just would like to reinforce usefulness and usability considerations in designing the measures.