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**Comments on “Connecting Health and Care for the Nation – A Shared Nationwide Interoperability Roadmap, DRAFT Version 1.0” (the “Roadmap”)**

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**Introduction**

The Roadmap is an amazing document. The reader is informed of the background and current status of efforts to advance interoperability of Health Information – related technologies and systems and, most importantly, a call to action addresses the many aspects and issues of achieving interoperability in the near and longer terms. The topic is complex with many threads and overlapping issues which must somehow be addressed to create a coherent path forward, and I believe that the document does this. The document is also very well organized, well written, and well presented. I applaud those who wrote and developed this document. It is an excellent starting point for the work to follow.

My comments are brief and are presented below as responses to the questions suggested in the Roadmap. I appreciate having the Roadmap as a handbook to the future of interoperability and am grateful for the opportunity to comment on it.

Respectfully,

Terry Bequette

Hinesburg, VT

As you review the Roadmap, please consider the following questions and submit your responses during the public comment period.

###### General

* 1. Are the actions proposed in the draft interoperability Roadmap the right actions to improve interoperability nationwide in the near term while working toward a learning health system in the long term?

*Response*: Yes; the proposed actions will result in improved interoperability in the near term and move us in the right direction. To that end, they are necessary actions and if successfully pursued would probably be sufficient.

* 1. What, if any, gaps need to be addressed?

*Response:* Health literacy and numeracy are critical to the success of many aspects of the interoperability roadmap and of healthcare reform in general. Category C4 “Education and digital health literacy for individuals” identifies a call to action in the near term and discusses other things that should occur in the longer term. My concern is that emphasizing *digital* health literacy may be a non-starter if health literacy is lagging to begin with, and I believe such is the case. I recently heard a presentation to the City Club of Portland Oregon by Dr. Dean Schillinger of the University of California San Francisco which I consider to be an eloquent and effective discussion of the importance of health literacy and numeracy in changing outcomes. I’ve been monitoring the website and this particular presentation is not yet posted for replaying but you can read about the event here: <http://www.pdxcityclub.org/calendar_day.asp?date=3/6/2015>

* 1. Is the timing of specific actions appropriate?

*Response:*  Yes, appropriate timing. No amount of time will suffice without the necessary collaboration and cooperation of stakeholders. But with collaboration and cooperation the timing of specific actions is appropriate and realistic.

* 1. Are the right actors/stakeholders associated with critical actions?

*Response:* Yes.

###### Priority Use Cases

* 1. Appendix H lists the priority use cases submitted to ONC through public comment, listening sessions, and federal agency discussions. The list is too lengthy and needs further prioritization. ***Please submit 3 priority use cases from this list that should inform priorities for the development of technical standards, policies and implementation specifications.***

*Response:* A simplified view of my prioritization model establishes the delivery of care at the point of care as the highest priority. Such care delivery requires access to accurate and complete health information, sufficient to the needs of the moment. A second priority is that providers in a patient’s network of care be aware of changes in the status of the patient’s situation or treatment. That awareness requires event notifications and information about transitions of care. The third priority is for patient engagement, to participate in the process of improving the quality and accuracy of health information and to manage consent so that providers in the network of care can access the patient’s health information as needed. There are several use cases that touch on these three priorities, but I have tried to select the use cases that are sufficiently broad in scope to incorporate some of the related use cases.

My choices for use cases are:

**26:** All providers in a care team will have unique access, authorization and auditing functionality from health IT systems necessary to fulfill their role on the care team. (related use cases are: 29; 33; 39; 41; 42; 45; 49.

**3:** The status of transitions of care should be available to sending and receiving providers to enable effective transitions and closure of all referral loops. (related use cases are: 9; 40)

**21:** Patients have access to and can conveniently manage all relevant consents to access or use their data. (related use cases are: 11; 17; 18; 19; 28; 37)

###### Governance

* 1. The draft interoperability roadmap includes a call to action for health IT stakeholders to come together to establish a coordinated governance process for nationwide interoperability. ONC would like to recognize and support this process once it is established. How can ONC best recognize and support the industry-led governance effort?

*Response:* Hunt Blair (The distributed Network LLC) has developed and circulated some detailed thoughts and comments on a coordinated governance process for nationwide interoperability. I believe a number of stakeholders are supportive of Hunt’s approach and I encourage ONC to endorse the approach and then participate to enable and support ensuing efforts. While I trust Hunt’s comments will be submitted through this comment process, a few of the key elements are presented here:

* Governance is the key interdependency of interoperability: we cannot achieve a scaled, nation-wide health, health care, research, and human services information supply chain absent a vendor-, payer-, and institution-agnostic governance process.
* Well-governed interoperability is essential to solve the problems the Roadmap identifies. Public and private partners should collaboratively take on the work to build a governance structure that appropriate to the complexity of what is required.
* We are too large and complex a nation for a “one size fits all” infrastructure. Governance – in the form of effective, comprehensive, nation-wide coordination – will enable “networks of networks” and modular, distributed, cross-boundary services to flourish. The key is making it easier by removing barriers, which is in everyone’s long-term interest.
* Interoperability must be governed with a commitment to open and unbiased exchange, organized and operated for the public good, and not subsidizing a limited institutional or corporate business model. Such exchange can and will be conducted by both private commercial, private non-profit, and public entities, united to serve the nation.
* That outcome is possible because the digital landscape of health data is best characterized by abundance – even overabundance – not scarcity. Distilling information and knowledge out of that abundance will provide work for many, many organizations and individuals, adding to our national treasury and well-being.
* The Roadmap calls for “*a single coordinated governance process*.” This is not to be mistaken for a centralized *government* process to “rule interoperability.”
* Given the modular, distributed nature of interoperability, there is no center from which to govern. Rather, governance itself must also be modular and distributed, designed to meet the needs of the use cases and the technical requirements at hand.
* Governance is good business practice: in conjunction with a core set of shared values and expanding inventory of use cases, actors across the interoperability landscape must come together to form durable, repeatable governance processes under which various aspects of interoperability can be managed and maintained, matched to operational business needs.

###### Supportive Business, Cultural, Clinical and Regulatory

* 1. How can private health plans and purchasers support providers to send, find or receive common clinical data across the care continuum through financial incentives? Should they align with federal policies that reinforce adoption of standards and certification?

*Response:* To answer the second question first, alignment with federal policies that reinforce adoption of standards and certification is recommended. Such alignment creates critical mass for support and helps to motivate vendor developments to integrate the standards and achieve certification.

Financial incentives to support providers to send, find or receive common clinical data across the care continuum could include capitated incentives to help offset the costs of query. Private health plans and purchasers could alternatively or additionally somehow cover some of the cost for HIE participation for providers. An example of the latter has been Vermont’s State HIT fund, where payers are taxed and the proceeds are allocated to HIT endeavors. The majority of proceeds over the years have gone to support the state’s designated entity for HIE. (Note, this Fund is due to sunset in 2017).

###### Privacy and Security Protections for Health Information

* 1. What security aspects of RESTful services need to be addressed in a standardized manner?
     + *(No Comment)*

###### Core Technical Standards and Functions

* 1. Which data elements in the proposed common clinical data set list need to be further standardized? And in what way?
     + *(No Comment)*
  2. Do you believe the approach proposed for Accurate Individual Data Matching will sufficiently address the industry needs and address current barriers?

*Response:*  Yes, I think the proposed approach will suffice.

###### Certification and Testing

* 1. In what ways can semantic interoperability be best tested? (e.g., C-CDA content and semantics)
     + *(No Comment)*

###### Measurement

###### I have no comments for this set of questions, with the exception of question number 4 (see below):

* 1. 1. Does the measurement and evaluation framework cover key areas? What concepts are missing?
  2. Which concepts from the framework are the most important to measure? What types of measures should be included in a "core" measure set?
  3. Should measurement focus on certain use cases, priority populations or at certain levels of the ecosystem (e.g., encounter, patient, provider, organization)?
  4. What other types of metrics have been successfully used at the local or regional level that might be considered for nationwide use? Would stakeholders be willing to propose novel metrics and provide "test beds" to assess the potential for nationwide use?

*Response:* I know that in Vermont, through the Blueprint for Health program, measures have been developed for Pediatrics and are being developed (or have been) for mental health. Data sets have been established for the state’s clinical data repository. Such development has not doubt occurred in other states and regions. A survey to determine what other metrics have been developed and are already being used would better inform this question and could lead to the positive inclusion of additional metrics going forward.

* 1. What measurement gaps should be prioritized and addressed quickly?
  2. What other available data sources at the national level could be leveraged to monitor progress?
  3. Are the potential mechanisms for addressing gaps adequate? What are other suggestions?
  4. How should data holders share information to support reporting on nationwide progress?
  5. What are appropriate, even if imperfect, sources of data for measuring impact in the short term? In the long term? Is there adequate data presently to start some measurement of impacts?