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National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health & Human Services
200 Independence Avenue S.W.
Suite 729-D
Washington D.C. 20201

Re: Interoperability Roadmap

Dear Dr. DeSalvo:

This letter is drawn in response to the invitation of the Office of the National Coordinator for Health Information Technology (“ONC”) for public comment on Draft Version 1.0 of the Connecting Health and Care for the Nation, a Shared Nationwide Interoperability Roadmap (interchangeably the “Interoperability Roadmap” or the “Roadmap”).

By way of introduction, my name is Michael Gallup. I am President of TeleTracking Technologies, Inc. (“TeleTracking”). TeleTracking, the world leader in automated hospital operations management, created the patient flow market over two decades ago with the world’s first online bed management system. Today, it coordinates care across a patient’s journey by automating daily functions, tracking and optimizing resources, speeding procedural throughput, managing infection risk and more. TeleTracking’s core mission is to help hospitals save lives by making their operations more efficient and by making sure the right patient is in the right place at the right time with the right resources.

TeleTracking, as the eight-time KLAS Patient Flow Category Leader and HFMA peer review designee, with over 900 clients throughout the U.S., Canada and U.K., is uniquely qualified to comment on the Interoperability Roadmap.

TeleTracking shares and supports the underlying premise of the Interoperability Roadmap, namely, technology that “facilitates the secure, efficient and effective sharing and use of electronic health information when and where it is needed is an important contributor to improving health outcomes, improving healthcare quality and lowering health care cost...”¹ However, we believe that the subject matter addressed in the Interoperability Roadmap is unnecessarily limited in scope, which will unduly restrict its effectiveness for no compelling reason.

In summary, the Roadmap focuses on actions that will enable patients and providers across the care continuum to send, receive, find and use a common set of electronic *clinical* information at the *nationwide* level by the end of 2017 (emphasis added).² We see two fundamental problems associated with this focus. First, potential cost savings and resulting care logistics coordination across the continuum are unnecessarily reduced and hampered, respectively, by limiting the focus to the interoperability associated with clinical information. And, second, there is currently a lack of interoperability within the “four walls” of the hospital, which is the foundation necessary for a national exchange of information. Without addressing the internal challenges, the external value will be compromised.

The draft Roadmap is limited to interoperability associated with clinical information. Administrative electronic health information, together with its intersection with the clinical side, while acknowledged as critical and worthy of consideration, are excluded from the scope of the Roadmap at this time.³ Moreover, it is uncertain whether the Roadmap similarly omits consideration of the interoperability of a provider’s own operations and how that intersects with and facilitates its clinical functions. The Roadmap does not define clinical or administrative electronic health information so it is uncertain whether operational information is included as

¹ Interoperability Roadmap at page 8.

² Interoperability Roadmap at page 10.

³ *Id.*

being in or out of scope in the initial draft Roadmap. However, certain of the priority interoperability use cases outlined in Appendix H to the Interoperability Roadmap clearly contemplate hospital operations and the operational/clinical intersection as factors for consideration. For example:

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.⁴
9. Providers should be alerted or have access to notifications that their attributed patients have had an ER visit, or an admission to or discharge from a hospital.⁵
17. Patients receive alerts and reminders for preventive screenings, care and medication regimens in a manner convenient to the configurable by the patient.⁶
39. Primary care providers share a basic set of patient information with specialists during referrals; specialists “close the information loop” by sending updated basic information back to the primary care provider.⁷
40. Hospitals automatically send an electronic notification and care summary to primary care providers when their patients are discharged.⁸

Each of these use cases go to patient and/or provider logistics and/or engagement, which are operational in nature and not clinical. It is beyond dispute that operational and/or supporting administrative data and workflow materially support the core functions of a provider’s patient care encounter.

Consequently, we believe the Roadmap should explicitly include within its principal focus operational data exchange/interoperability as a means of reducing costs and improving

⁴ Interoperability Roadmap at Appendix H.

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

coordination of patient care. There is no reason, stated or otherwise, to limit interoperability within the Roadmap to a common clinical data set. To the contrary, as noted, operational data is critical to maximizing the value of the clinical data. Patient-centric examples which support this proposition include reductions associated with long wait times, ambulance diversions, patients leaving without being seen, boarding, extended length of hospital stays, patients being treated in a unit not ideal to deliver their appropriate care needs, and patients being unable to move to higher or lower levels of care due to lack of capacity. Each of these identified challenges illustrates the inextricable impact of operational activity on clinical services and emphasizes the compelling need to pursue interoperability across both operational and clinical processes on a simultaneous basis. Simply put, interoperability supporting operational data should not be artificially carved “out of scope.” The Roadmap should specifically define and identify operational interoperability as a focal point to improving healthcare outcomes, quality and cost.

Nor does a two-step roadmap that addresses clinical issues first and operational issues later offer a good solution. It will be more costly to manage in two steps and more important we will be delaying achievement of substantial cost savings. Care processes built upon suboptimal operational data flow may pose significant challenges in both the near and long term. By way of illustration, priority interoperability use case number 47 provides as follows: “[d]isaster relief medical staff members have access to necessary and relevant health information so that they may provide appropriate care to individuals during an emergency.”⁹ This use case should be expanded to include bed availability, which is logistical, operational and a prerequisite to providing care.

How can patients and providers share information externally when the doors to communicate internally are not fully opened?

The House passed legislation earlier this year mandating interoperability for U.S healthcare information systems by the end of 2017. This follows a Congressional investigation into the practice by some EMR vendors of using “information blocking” as a competitive tactic to expand market share.

⁹ *Id.*

We welcome Congress' attention to this issue because it is clear to us and many healthcare executives that hospitals function much more efficiently when clinical and operational systems can "talk" to each other. This leads to cost saving, revenue generation and most importantly, more effective caregiving.¹⁰ Otherwise, when information systems are blocked, the cost to patients in terms of health and well-being rises exponentially because of delays in delivering appropriate care and increased potential for medical errors, both of which increase the rate of morbidity and mortality. These outcomes run directly counter to the intent of the Congress when it approved billions in taxpayer funds to stimulate the widespread adoption of electronic medical records (EMRs) and the Roadmap's intent to design a learning health system. The Roadmap is uniquely poised to support this initiative by mandating repeatable and scalable internal interoperability as a prerequisite to nationwide clinical interoperability.

In conclusion, as recently stated by HHS Secretary Sylvia Burwell in announcing proposed rules regarding the Medicare and Medicaid Electronic Health Records Incentive Programs to improve and support the path to nationwide interoperability, "[t]he flow of information is fundamental to achieving a health system that delivers better care, smarter spending, and healthier people." Ms. Burwell did not limit her remarks to clinical information or external exchanges of information; nor should the Interoperability Roadmap. The collection and exchange of data, including operational data, will drive the eventual ability of the Roadmap to strengthen healthcare delivery and fulfill the ONC's stated goals.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Michael Gallup", written over a horizontal line.

Michael Gallup

President

¹⁰ Interoperability within the four walls of some hospitals and health systems is already in place and demonstrating efficiency and resulting cost savings. TeleTracking welcomes an opportunity to share such outcomes with the ONC.