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Good morning. I am A. John Blair, III, MD. I offer the perspective of a health care and technology executive who spent many years in clinical practice. I am CEO of MedAllies, a health information service provider company, and president of Taconic IPA a 5,000-plus member physician group. Both are based in the Hudson Valley of New York.

In my MedAllies role, I have extensive experience with Direct. As this panel knows, the Direct Project is a collaborative effort championed by the ONC to improve the transport of structured and unstructured health information across disparate EHR systems. The information transfer is secure, fast, inexpensive and interoperable. Importantly, it supports providers as they strive to improve patient care and meet Meaningful Use requirements. MedAllies has been involved with the Direct Project since its inception.

**Parallel paths: Transformation and interoperability**

In New York, we have been working on two parallel paths; those two paths are now colliding. One path is our practice-transformation efforts around patient-centered medical homes and now, patient-centered medical neighborhoods. Because of these efforts, Taconic IPA shepherded numerous practices--more than 500 primary care physicians--to recognition as National Committee for Quality Assurance Level 3 medical homes.

The second path is our work on EHR interoperability and, more recently, the use of Direct protocols to achieve that interoperability.

Our practice-transformation efforts are moving out of the individual practice and into the neighborhood, just as we are moving Direct into a market offering. We see tremendous interest and demand from advanced primary care practices--and the specialists they work with--for interoperability. We are also witnessing increasing interest from hospitals around care transition. The interest is driven by the 30-day re-admission penalties, ACOs and other care coordination projects in our region.

As we move our Direct efforts from a pilot program into a statewide offering--which went live last week on the Statewide Health Information Network of New York --we recognize that interoperability must be more than sending medical email to inboxes. Interoperability demands true EHR integration--integration at the point of care and consistent with each provider's workflow.

**Stage 2 Meaningful Use not the problem**

What we have found, being involved in health information exchange for more than a decade and with Direct from the beginning, is that the technical integration required for stage 2 Meaningful Use is not

the real issue. The vendors are ready for that. The current technology addressed in Stage 2 will work. This is not a heavy lift; in fact, it is eminently interoperable.

To the degree EHR vendors are paying attention to the utility of their systems for transitions of care--referrals, consults, discharges, etc.--they will meet the providers' needs; we are very confident there will be widespread use and a marked uptick in interoperability. Our belief is based on our two years of work with providers--across multiple settings--who have shown interest in these capabilities and strong satisfaction with what they have demonstrated.

Instead, the real issue relates to how technology serves providers. We have discovered that the user interface (UI) within the EHR vendor technology currently does not anticipate full clinical interoperability around transitions of care. This gap is understandable because intersystem EHR interoperability has not been available in the market. In addition, provider adoption and usage of EHR technology was not previously at a level in the market to justify provider reliance on the EHR as a communication tool.

The issues with which we must grapple are functionality of the application for the providers and its clinical relevance. Along those same lines, as we move to two-factor authentication , we need to be mindful of the impact this will have on provider workflow. The EHR is becoming the access point for many networks (EPCS, Direct, HIE query). So, for example, will the provider have to authenticate at each transaction or at each session? The two approaches would have a markedly different effect on providers and their resistance--or lack thereof. This could have a profound impact on adoption and use of EHR functionality related to interoperability.

**Make it relevant**

What would it take to increase interoperability? Make it clinically relevant and give providers the assurance it will increase efficiency. The technology must respect clinical workflow. At end of the day, it comes down to relevance to the providers. If the provider honestly believes these enhancements will improve care and efficiency--and particularly if they are indirectly tied to increased reimbursements for improved health care value--interoperability will advance rapidly. If the providers do not believe this, nothing else we do here will make much of a difference in the long run.