VDT Listening Session

Jitin Asnaani | Director, Technology Standards & Policy | athenahealth

02.13.2014

athenahealth is a cloud-based solution for Practice Management, Electronic Health Records, Patient Communication and Care Coordination. Our vision is to become a health information backbone that helps health care work as it should. Critical to this vision is the support and advocacy for broadly-used standards that enable providers, patients, public health agencies, healthcare innovators, and a variety of other healthcare participants to share the right information that delivers a better user experience, better health outcomes, and lower costs. To that end, athenahealth has been an active participant in several government- and community-driven initiatives, such as the S&I Framework, Directrust.org, and the CommonWell Health Alliance.

athenahealth services are delivered through a single-instance, multi-tenant platform, so all of our 40,000+ providers are always on exactly the same version of our software at the same time. As such, when we certified as a Meaningful Use 2014 Edition complete EHR last June, all of our customers were immediately using the certified product. All of our customers enjoy this product upgrade as part of their service package, and there are no additional charges for functionality such as those required for View, Download, Transmit (VDT).

The VDT capabilities are all natively built-into the patient portal, including the ability to:

- View and navigate across the summary.
- Download the summary in both PDF and CCDA XML formats.
- Transmit the summary to a third-party as a CCDA via Direct Project protocols.
- View a history of all the VDT actions taken on their record.

Early Findings

In the course of implementing, piloting and releasing VDT to production over the past few months, we have made several observations – with certainly more to come as usage really picks up steam throughout 2014.

First some clear evidence of success: the use of a single payload standard (i.e., the CCDA) simplified and rationalized the investment in building VDT capabilities. It is also enabling simpler, faster and more reliable connectivity as we connect more and more HISPs to our network. The use of a single transport mechanism has been of limited help in this regard; enabling the usage of other broadly-used standards-based transport mechanisms would have created a faster ramp-up of real-world exchange, since some endpoints already use them. But on the whole this has not been a major issue, and the silver lining is that it has required us to refine our technical abilities to leverage Direct. Certainly, the move to interoperable electronic communication is a step in the right direction.

There are some key opportunities for future improvement. Let me start with one that is granular and tactical. The CCDA is a sensible standard that requires an appropriately constrained set of core data

elements while enabling the flexible addition of other useful elements. However, as part of certification, each vendor needed to validate the VDT message against the Transport Testing Tool, and this tool returns error messages when supplemental data is added to the CCDA (e.g., percentiles for height). As such, our options are either to limit the information that providers share to the elements in the CCDA, or to create a separate human-readable document that diverges from the more limited CCDA implementation. But providers have enthusiastically made it clear that they cannot provide quality care by strictly following the data constraints of the CCDA. So clearly there is an opportunity here to enhance the functionality or redefine the role of the Transport Testing Tool, so that the human-readable and CCDA versions of the summary mirror each other.

A more strategic consideration is the fact that there are different documents that patients are required to be able to access for Meaningful Use, namely the Ambulatory Summary with historical data and the Clinical Summary for episodic care. This not only created the need for greater training of our providers and potential confusion for patients, but has also required us to continue investing in making the user experience around these individual documents as *non-invasive* as possible to providers while still meeting the MU measure requirements. Why "non-invasive"? Because while both of these documents do indeed have a place in patient care, the problem is that they distract both providers and patients from experiencing and leveraging other aspects of the patient portal that are more critical, such as, for example, effective engagement with population health campaigns.

This suggests a degree of caution, as the early results of Meaningful Use are a clear reminder to us that there are still harder problems to solve in the present; and particularly for consumers, these problems are not interoperability-related but rather are cultural and incentive-driven. In fact after 1.5 months of usage of our VDT solution, which is built into our KLAS #1-ranked patient portal, there have been essentially no requests from patients to use their own Direct address or to send to a specific Direct address; those very few who have requested transfers of their ambulatory summaries have done so through our integration into Microsoft HealthVault, where the Direct address is largely hidden from the user, thus making it more intuitive. Our number one problem, and that of largely all patient portals, is getting the patient to visit the portal at all.

Summary

On the whole, we are very supportive of the direction of both VDT and Blue Button Plus (BB+), and both as a vendor and as an industry, there is no lack of energy, enthusiasm and know-how to create great consumer healthcare experiences. VDT and BB+ are great first steps, and will largely mitigate technological barriers. The bigger steps ahead are going to be the cultural sea-change required among consumers, driven by payment innovation such as PCMH and Accountable Care that give an organic business incentive for providers and other care-givers to influence consumer behavior. With the plumbing on its way to being built, I expect the data to start flowing, and the Triple Aim to finally have an active ally in the healthcare consumer.