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Female: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders and health innovation, health policy, care delivery and great minds who are shaping the health care of the future. This week, Mark and Margaret speak with Jitin Asnaani, Founding Executive Director of the CommonWell Alliance, not for profit trade association, a health care and technology organizations that are working together to create universal access to health's data nationwide. The organization has thousands of providers, payers, electronic health entities and organizations utilizing their platform to share health data and exchange health information.

Lori Robertson also checks in, Managing Editor of FactCheck.org looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and wellbeing in everyday lives. If you have comments please email us at chcradio@chc1.com or find us on Facebook, Twitter, iTunes or wherever you listen to podcast. You can ask Alexa to play the program Conversations on Health Care. Now stay tuned for our interview with Jitin Asnaani of the CommonWell Alliance on Conversations on Health Care.

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Mark: We're speaking today with Jitin Asnaani, First Executive Director of the CommonWell Health Alliance a not for profit trade association of health care and technology organizations working together to create universal access to health data nationwide. Prior to that he was Director of Athenahealth where he helped build a cloud based interoperability platform. He also contributed to the Federal Advisory Committees for Athenahealth and HL7 Argonaut Project as well as serving in the Office of the National Coordinator for Health IT. He earned his bachelor's in science at MIT and earned his MBA from Harvard Business School. Jitin welcome to Conversations on Health Care.

Jitin: My pleasure to be here.

Mark: Yeah. I think everybody knows that as the amount of available health data continues to grow, interoperability of health information systems has also grown as a crucial issue and problem to solve. I think that's one of the founding goals of the CommonWell Alliance. I'm wondering if you can help our listeners understand how much closer we've come to the goal of making health data readily available to patients and for providers who rely on it.

Jitin: Absolutely. The quests to become perfectly interoperable and have data share so seamlessly across systems that has to actually continue as medicine itself evolves as the types of data out there evolve in response to kind of changes in therapeutics and diagnosis abilities and so on. The big first step for us that we're trying to accomplish is to get the spigots running. 10 years ago when I enter this industry, there was virtually no multiparty data exchange happening. There were some point to point exchange exceedingly expensive, but there was no way to get a whole party to connect to each other except in small localized environments. Now, here we are with things like CommonWell leading the way, enabling broad scale nationwide cross community exchange of data in support of patient access and other purposes.

If you look at a CommonWell network we enable more than 11,000 different sites [inaudible 00:03:24] all across the US to be able to exchange data and that number is just going by thousands every year. We're working with others who are trying to enable such goals as well. We really are at a place now where the pipes are there, our water is running and now we're working on making the data that flows for them better. How do we make the insights from the data more actionable? As we get to that we'd think about turning them into action in terms of better patient care. But now we've taken -- the work is done both within the CommonWell and with partners outside CommonWell. We're at a stage where we can say, yes we're very close to being at the precipice of stage two where the data is really flowing, so that providers can use it in a wide variety of contextual situations with patients.

Margaret: Well, we have seen such a dramatic shift in the American health system over this past decade. Most health systems have gotten off paper and onto electronic health records. Many people say that the large EHR entities in the marketplace have made the interoperability more difficult than it needs to be. We're curious about the genesis of the CommonWell Alliance, where do the idea for this and the identification of the need for a new organization the CommonWell Alliance to exist. Maybe you could just tell us a little more about how these entities are building an infrastructure that's really going to make for a better flow of health data between systems and, of course, to the patients.

Jitin: Yeah, if you think about EHRs and their adoption, so over the course of 40 years there was a very slow pace of EHR adoption across the industry. Less than 20% of all health care was electronic. Then came the EHR incentive programs, out of the High Tech Act and what you had was an artificial kind of pumping up of this part of the industry where if there was an incentivized push for our provider organizations to adopt EHRs. On the one hand you could say, this is great, on the flipside having worked at an EHR vendor I can tell you that was -- because it was an artificial pump, it was -- it was a land grab. You had to run out into the market with what you had and whatever you could build on the fly to try to have an opportunity, get part of that sudden opportunity to electronify these paper based practices in institutions.

In some ways got a little bit backwards, the jump to electronification without thinking about the interoperability or as interoperability is follow on. What they are driving was the adoption of EHRs which were not design for interoperability. When you're living in a paper based world you're interoperability solution is a fax machine. Interoperability was great in a paper based world for paper based interoperability. I'm being a little tongue in cheek there, of course. But the reality is that that was not a problem, it suddenly became a problem in a very quick timeframe artificially, because of meaning for use. What happened in 2012 and 2013 timeframe when the EHRs started realizing, hey, this is the way the world is going, we're all going to have electronic records whether mine or my competitors.

The reality is to have these records be able to exchange with each other. Given kind of the knowledge of how federal regulation tends to act coming from top down as in from the federal government on down to the EHR vendors, is just found not be as good a solution as if the industry had just taken with themselves. We took it upon ourselves, that time when CommonWell was just founded it was just five substantial vendors, Athenahealth, Greenway Health, Sonar, Allscripts and McKesson. Those five got together and said, hey we believe that data exchange is going to be critical. We should be enabling caregivers across the country to be able to find the patient's data regardless of what EHR record the current or previous providers have used.

We came together and decided we create basically a shared services platform which included a record locator service and a patient index so that we really could tell where the patient has been regardless of what EHR they're using. It allowed us to be able to exchange data amongst each other without having to build point to point connections. That was the genesis of it, it was this notion that we know where we need to go as an industry, we know how we can get there, let's build something that we know works because we are -- EHRs are going to be on the hook to build them. Then let's open it up so that the entire industry can join us, the government can join us, and we really can take care of the patients across the care continuum.

Mark: I love the notion that you think we're on this precipice of having the data flow and certainly to make that happen we need to sort of understand the standards that are required to facilitate the building of this infrastructure. There's this growing enthusiasm for something called FHIR and that's not the flame but rather this is a fast health care interoperability resources technology. That was developed by the folks at HL7 of the global authority for interoperability and health information technology and through the Argonaut Project. I'm wondering if you could tell us more about the role of FHIR and why it's so vital to scaling up innovation in the health information technology arena.

Jitin: So, what is FHIR? It is based off of much more modern 21st century internet protocols to share electronic data. It represents -- it did a format for exchanging what an industry luminarian name Wes Rishel likes to call molecules of data. In other words, just the data I'm interested in, not necessarily the entire patient chart. The ability to work with modern protocols means now you can attract into this industry a younger and newer generation of participants from Silicon Valley, folks from technical colleges and universities across the country. Developing innovations without requiring a lengthy participation in the industry in the first place to really understand how these old ancient protocols that we use typically in this industry that have been the ministry of the industry these last 40 something years. If you get it right and everybody implements the same modern protocols everywhere, in other words actually standardize it. Then that means that somebody who's building a startup can work with several different EHRs, then that second part about the data being available in molecules means it can participant in other types of exchange.

The fact that you can kind of pick and choose the type of data you want to exchange, it should be a game changer. You should be able to create innovations that are very, very focused on particular things people need like being able to find immunizations for your child or something. If you're going to take them to soccer camp and they need all of that. Things like CommonWell who provides the ability to go and find where the data is to correlated to a single individual, become even more useful in this scenario. In fact it reduces our cost, because right now we do entirely document best exchange with these old legacy systems and our ability to participate with those participants became cheaper because everybody is now using much more modern protocols as directed by the Argonaut Project.

Margaret: Well, just recently I think there was a fair amount of anticipation leading up to this year's HIMSS Global Conference. It was marked by some big announcements from the Centers for Medicare and Medicaid, services from the Administrator Seema Verma and others within HHS who I understand announced some pretty bold new rules for advancing health data liquidity. I understand that this rule says that by 2020 no patient should have to wait more than 24 hours to gain access to their own health records electronically and at no cost to them. This is huge, it signals a new incentive certainly for health systems to improve health information sharing. This is a radical shift. Tell us why you think these new CMS rules are so significant.

Jitin: If you just think about what the experience is today for an individual participating health care. We've heard stories from our neighbors and our friends, and then we've heard it from very high profile individuals like Seema Verma and the care of her husband or former Vice President Biden and the care of his son. If you think about all these scenarios, underlying theme is there just a lack of empowerments. As an individual in this country when you are participating in your health care, whether your outcome is good or bad you are a victim of the health care system here, that's the issue. When CommonWell was formed our notion was the caregiver should really get the data no matter where the patients receive care.

The caregiver was always broadly defined to be -- it could be the clinical provider, it could be the patient themselves, it could be the parents, the teachers whoever. We expected to the bulk of the exchange would be driven by clinical providers, physicians, nurses and the like, and that has borne out to be true. But from the very beginning it was all about enabling it for whoever in needs to have authorize access to take care of that patient. As CMS [inaudible 00:12:52] two things, they have said that yes the individual must be empowered, and they are focused on the individual. Even though I'm not sure the immediate volumes will come from the individual, although you can certainly argue that over the next three to five years. We expect more health care to be driven by individuals themselves.

Not only are we moving in the direction of more interoperability, we are really moving in a direction of greater empowerment. That's what I really love about the rules that have come out. The second thing is this notion that they have really forcing adoption off this FHIR APRs. To the extent that we know everywhere that the same set of APRs are going to be utilized for the majority of the health system that participates with CMS as their peer, that enables higher interoperability. Not only will it become utilized for the purposes of enabling patients to get their care, but it'll also be utilized by others who want to participate in the care.

What CommonWell has done in the past, we already have patients to connect to us. In fact, we've enabled this for the last three years, and I think this I think will inserts the kind of confidence that a EHR or patient app developer is going to feel that, hey, if I participate here I know for sure that other people that participate will have the data, will have it in a format that I can reliably build software, I can build innovations on top off. We've already done some parts of it in CommonWell, but the fact that CMS is really going to drive the industry to standardize and to accept the patient has a right to their data, I think will be a big boon for all of us who are just trying to make interoperability ubiquitous.

Mark: We're speaking today with Jitin Asnaani the First Executive Director of the CommonWell Health Alliance a not for profit trade association of health care and technology organizations working together to create universal access to health data nationwide, and was one of the founders of the Argonaut Project. Jitin you say that we've reached an interesting pivot point where we've gone from not having enough data to all of a sudden having too much of it. It seems that there's just increasing demand for information, we at our health center engage with the All of Us Project, paring together genomic information, health information, social determinants. There's just an enormous amount of new streams of data flooding into the system. What's the next five years look like in terms of synthesizing this information?

Jitin: If you just think about the different pieces you need in your health data puzzle as a provider, you know you had disparate data sources. You have the clinical chart data, the social determinant data, the genomics data and the like, right? You have a system that feeds this to you, right, an actual EHR other HIT system, you don't touch and feel CommonWell that sort of like the Version Network. It's somewhere in the background doing its thing. You need to know where these data sources are and get them connected at the time you needed for the patient you needed for. Here's what I see happening Mark, as folks realize that there is a lot more data that they need in their locality in order to be able to exchange data, I see them making a lot of point to point connections. Let me just connect to that local state agency that has the housing information for these patients who have socioeconomic issues. In the meantime I'm going to connect to CommonWell because I'll be able to get the clinical chart data on the patient. Then it's going to come up here into my EHR, my EHR provided by X, Y, Z vendor for the patient for whom I really need that information, I will utilize it.

I see that bearing not given right now, Mark, because the participants on the CommonWell network who immediately started using the service to a great degree were actually PCPs who are seeing brand new patients, because they were so desperate for any data that even if their data came across from some location and was not in a well formatted. They would still at least skin through it so that they had something. Overtime as the data become better we have more and more use cases where people are utilizing it in more and more situations. I think this is the big transformation. As EHRs make the transition from enterprise software systems that have interoperability as a feature towards interoperable web based systems that have user facing functionality that makes you more intelligent. The experience of users is going to get better. As the goal post moves from, hey do I check the box on functionality to how am I creating an experience that's so good in light of the fact that I'm seeing more and more data coming into my system. As we make that transition, I think the experience for providers and caregivers is going to dramatically improve.

My sense is that CMS has already seen this and they are trying to drive more usability related regulation. My sense is that EHR vendors investing more and more in this space. Some of the newest EHRs on the block kind of really think of themselves as interoperable to platforms that have EHR functionality build on top of it. I think as the world moves in that direction the realization that all these other data sources out there, it's just going to be table sticks. If you cannot figure out how to deal with all the different types of data out there and present it in a friendly way to your users, you have illimited shelf life. I see our role to be very specific service role there, right, and it'll take us a long time to get all the data sources connected because some of them are kind of locked away in these government agencies. As we start getting there, EHR vendors also getting there, and in the meantime people really are already starting to tap into those valuable sets of data. Genomic data is probably going to be a critical piece of this whole puzzle, but it's subject to all the same constraints and force with the evolution.

Margaret: We've been speaking today Jitin Asnaani, First Executive Director of the CommonWell Health Alliance a not for profit trade association of health care and technology organizations that are working together to create universal access to health data nationwide. You can learn more about their exciting work by going to CommonWell Alliance.org or on Twitter @CommonWell or follow him @Jitin, that's J-I-T-I-N. Jitin thank you for your incredibly important contributions to health data interoperability for being such a great communicator about the work that you're doing and for joining us today on Conversations on Health Care.

Jitin: Thank you so much for having me.

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Mark: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori: In a political rally in El Paso, President Donald Trump falsely suggested that fact checkers didn't hold then President Barack Obama accountable for his false promise that if you like your health care plan or your doctor you can keep them under the Affordable Care Act. We wrote as far back as 2009 that Obama couldn't make that promise to everyone. Trump said, "You can keep your doctor, remember that?" Then he called out the fact checkers saying, "Hey, where are the fact checkers? You know, some of the most dishonest people in the media are the so called fact checkers." In August 2009 we wrote under the Health Care Bills been debated at the time some employers might have to change insurance plan to meet benefit requirements and others could drop coverage and pay a penalty instead. The nonpartisan congressional budget office estimated that three million people with insurance through their employers would not be offered coverage. We sighted that report and explained in detail how the different versions of health care legislation could affect the ability of some to keep the same insurance plan.

Obama had made the claim and in August 15th 2009 town hall event as he try to garner public support for his health care overhaul plan. He told the crowd, "If you like your health care plan you keep your health care plan." When asked about the claim in a 2009 press conference, Obama said he meant, "The government is not going to make you change plans under health reform." But we noted that's not exactly the claim he continued to make. Obama repeated his talking point over the years and we repeatedly wrote about it. His claim made our list of health care whoppers in 2010 and a roundup of Obama Care myth in September 2013. In October 2013 reality caught up with Obama's claim when many Americans who bought coverage on the individual market began getting letters from their insurance companies saying they'd have to buy a new policy because of the ACA's minimum benefit requirements. The fact is we held Obama to the same standard that we hold Trump. That's my fact check for this week, I am Lori Robertson, Managing Editor of FactCheck.org.

Margaret: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked email us at chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Mark: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Fitness trackers have become all the rage, but another trend has emerged in the age of wearable devices. After a few months about a third of user simply stop using them. The reality capture the imagination of Tufts University School of Medicine, Professor Dr. Lisa Gualtieri.

Lisa: I thought what if you could take all of these abandoned trackers and give them to the people who could benefit most from them.

Mark: She thought what if we could get disinterested owners to donate their used fitness trackers to be repurposed and donated to underserved populations.

Lisa: A lot of the work that we've been doing has been with older adults, racial and ethnic minorities. For a lot of people the cost is precipitate so I think that that's a barrier.

Mark: In 2015 she launched her nonprofit enterprise Recycle Health an online social media campaign which seeks donated wearable devices to provide these expensive devices for free to those in need. She partnered with organizations working with low income adults, seniors in fall prevention programs and veterans as well.

Lisa: What we do is talk to people about how access, how sedentary they are in coming up with a reasonable and achievable goal. They might start off with 2000, 3000 steps as their goal, but they know how to make that higher when they're ready to.

Mark: Recycle Health, a simple repurposing of personalized wearables providing these tools for free to vulnerable populations empowering them to engage in activities that can improve their own health. Now that's a bright idea.

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Mark: You've been listening Conversations on Health Care I'm Mark Masselli.

Margaret: And I'm Margaret Flinter.

Mark: Peace and health.

Female: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at chcradio.com, iTunes or wherever you listen to podcast. If you have comments please email us at chcradio@chc1.com or find us on

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