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Health Information Technology Advisory Committee
The Office of the National Coordinator for Health Information Technology

Health Interoperability Outcomes 2030
Outcome Statements Submitted by HITAC Members   June 9, 2021

"Because of interoperability, before/by 2030…"
"Because of interoperability, before/by 2030 [who] will [what]."

1. Health equity

a. People with disabilities will experience health equity no matter where they live or how they connect. (**C. Petersen**)

b. Standards around data for the conditions in which people live, learn, work, and play will enable the incorporation of and ability to address the non-clinical elements that impact individual and population health into overall healthcare. (**S. Turney**)

2. Empowered consumers / consumer well-being

a. All patients will have readily available access to all of their health information and pricing data on their smartphones, through the app of their choice and with the ability to share it with whomever they choose. These data shall remain in complete control of the patient to opt out or in of any file sharing… (**C. Fisher**)

b. All pricing data, including total, bundled prices (both discounted cash prices and insurance-negotiated rates) will be provided digitally and agreed upon by the consumer in advance of care… (**C. Fisher**)

c. Individuals will actively manage their health with self-management tools that include their care team (regardless of location and system) and data collected by them and about them without special effort. (**A. Malec**)

d. Adolescents and young adults with cancer will be able to enjoy all the life experiences enjoyed by others their age who don't need to coordinate complex care. (**C. Petersen**)

e. Patients will have easy access to their longitudinal medical record inclusive of all care they have received across the care continuum. (**D. Webb**)

f. A consumer can manage their care, request appointments, get test results and check their claims from the same portal on their phone. (**S. Turney**)

g. I have the ability to customize my consumer experience which allows me to connect all of my EMR portals into one experience. (**S. Turney**)

h. I will always have access to medical advice that is tailored to my complete/accurate medical history. (**S. Turney**)

i. Meaningful health care costs are more transparent and available for comparison by the consumer in the application of their choosing. (**S. Turney**)

j. I will always be alerted when my medical information has been checked for eligibility or payment and I can see where my information was used. (**S. Turney**)

k. I have the ability to use a consent and authentication provider of my choosing to access all of my health care portals through one app. (**S. Turney**)

l. I have the ability to use a digital health card that I store in my wallet and my EMR system can read digitally. (**S. Turney**)

m. I can have the option to engage with 3rd parties who can enable me to find ways to live a healthier life in ways and in specifics not offered by the standard EMR. (**B. Oliver**)

3. Health IT usability & safety

a. At least half of EHRs will be rated as having excellent usability by at least half of providers. (**K. Kawamoto**)

b. Preventable medical errors will not be a leading cause of death. (**K. Kawamoto**)

c. Older adults who receive health-promoting services in a variety of non-healthcare settings will get their needs met without needing to master complicated technologies. (**C. Petersen**)

4. Public health

a. Public health data is available to all health care stakeholders required to use, manage and report the data as permitted by the consumer to support the consumer and public health purposes. (**S. Turney)**

b. Providers, labs and public health will have robust bidirectional exchange to facilitate both emergency/pandemic response and routine public health workflow. (**S. Lane**)

c. Every state will have an automated public health surveillance system. (**J. Kansky**)

d. Every state will be monitoring the same public health measures and parameters and sharing them appropriately with the public, providers, payers, and the federal government in a standard way. (**J. Kansky**)

e. Healthcare providers, patients, public health departments, laboratory testing entities, PPE suppliers and other key stakeholders, will no longer have to implement and maintain time- and resource-intensive point-to-point connections and public health agencies will have easy access to the data they need to support an informed response to public health crises. (**J. Jiris**)

5. Health IT infrastructure / data sharing expectations

a. All stakeholders will be exchanging health data over a national trusted exchange framework providing a single onramp to health data without special effort. (**S. Lane**)

b. Providers across multiple health systems will have synchronized information and communication allowing for better health outcomes and shared decision making amongst patient and caregivers. (**A. Snyder**)

c. Payers and providers have implemented fully integrated, bi-directional data sharing that allow a consumer's health information to be available where it is needed, when it is needed for the purposes that the consumer specifies without any special effort. (**S. Turney)**

d. Every state will have a statewide health data utility / health information exchange exchanging data with every other state and the federal government. (**J. Kansky**)

e. Healthcare providers (large and small), patients, payors and other important stakeholders will have easy access to the appropriate information for the right patient at the right time on a national scale with no special effort. (**J. Jiris**)

f. Providers are able to access a patient's complete health history within clinician workflow through trusted data exchange systems to allow for improved clinical decision making, more thorough care conversations with patients, and more efficient and coordinated delivery of care. (**J. Jiris**)

6. Care coordination / delivery

a. HCBS (Home and Community Based Service) providers will be paid to share their daily observations of function, cognition, nutrition, medication management and fall risk with medical service providers using standardized data elements from the CMS DEL (Data Element Library). (**T. O'Malley**)

b. Transition of care documents to and from Acute and Post-acute care settings will include semantically interoperable data elements leading to improved quality and efficiency with less provider burden. (**T. O'Malley**)

c. Patients and their caregivers will be less burdened with being the point of exchange of information which will allow them to focus on their health and living their best lives. (**A. Snyder**)

d. Orders, results, referrals, discharges, etc. will all be automated and information rich experiences with all care team members fully up to date. (**A. Malec**)

e. Providers will have the ability to access all of a patient's current and past EHI in real time. (**S. Lane**)

f. I hope that when I see a new patient in the office, I can have their complete medical record from day 1. (**B. Oliver**)

g. Most prior authorizations are approved digitally and near real time. (**S. Turney**)

h. Patients will receive at least 80% of recommended care. (**K. Kawamoto**)

7. Research into action / marketplace innovations

a. Scientists of medicine will create millions of new jobs to leverage intelligent technologies to rapidly deliver equitable cures to solve the most challenging of diseases. (**A. Miri**)

b. We will continuously evaluate and publish reports on treatment and care plan alternatives that lead to optimal treatment plans and novel combinations of therapies improving health and healthspan. (**A. Malec**)

c. Patient-researchers will, with informed consent and in compliance with data governance policies and standards, be able to access patient-generated health data (PGHD) to investigate questions of interest to patients/caregivers and develop innovative patient/consumer-focused products and services that improve health outcomes. (**C. Petersen**)