

**HIT Policy Committee
Certification/Adoption Workgroup
Long-Term and Post-Acute Care (LTPAC) Virtual Hearing
Transcript
December 12, 2013**

Attendance

Members attended:

- John Derr
- Paul Egerman
- Jennie Harvell
- Joseph Heyman
- George Hripcsak
- Stanley Huff
- Marc Probst
- Martin Rice
- Paul Tang
- Larry Wolf

Members absent:

- Joan Ash
- Maureen Boyle
- Carl Dvorak
-
- Elizabeth Johnson
- Mike Lardieri
- Martin Rice
- Donald Rucker
- Micky Tripathi

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Good afternoon, everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee Certification and Adoption Workgroup. This is a hearing on certification for long term post-acute care settings. This is a public call and there will be time for public comment at the end of today's hearing. As a reminder to everyone who is speaking, if you could please state your name before speaking, it would be appreciated, as this meeting is being transcribed and recorded.

I'll now take roll. Marc Probst?

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Larry Wolf?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Mike Lardieri? Joan Ash? John Derr?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Carl Dvorak? Paul Egerman?

Sasha Termack – EpicCare

This is Sasha, and I'm attending on behalf of Carl Dvorak.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Actually, we're not allowed to have alternates. I'll follow up with you, Sasha. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Joe Heyman? George Hripcsak?

George Hripcsak, MD, MS – Columbia University

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Stanley Huff?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Liz Johnson? Donald Rucker? Paul Tang?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Micky Tripathi? Maureen Boyle? Jennie Harvell?

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging & Long-Term Care Policy

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

And are there any ONC staff members on the line?

Elizabeth Palena-Hall – Office of the National Coordinator

This is Liz Palena-Hall.

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator
Elise Anthony.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Liz and Elise, and I will turn it back to you, Larry, to make a few opening remarks.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I'd like to welcome everybody to this meeting. We have a pretty packed day. We've got six panels. We'll be following our usual format. We'll each have five minutes to present. After they all present, we'll have some time for discussion. It's been a great journey to get here, if you will. We've had several weeks of discussion among the work group members and we had a presentation last week that looked at some of the background on the LTPAC settings and then after that, there was a meeting of the Health IT Policy Committee that had its own lively discussion and some feedback from ONC in terms of their clearly stated intention to create a certification program for LTPAC and behavioral health, and that they were looking for recommendations on how that program should be structured and what the criteria might look like. Today's hearing is a chance for us to really listen and learn from the panelists, a great time to ask questions—I know this committee will not be shy in asking questions—and looking to understand how these settings are like and not like the eligible hospitals and eligible providers that we've been dealing with several years as part of the meaningful use framework and how that might affect the certification criteria.

The work group and the larger policy committee clearly had a sense that there are some things that are really essential to providing good care in our diverse set of care settings in the U.S. around information exchange and interoperability and a strong commitment to privacy and security as part of that. As we look at these settings, where does that actually play out? What are the key things we should be looking at for information exchange that actually has value to the providers, and anything they can tell us about what they've already done around information exchange, interoperability, how existing standards and criteria are working and where we are to go with them.

Then, beyond that, looking at things like what's in the ACHR? So, we have existing certification criteria that's been developed and honed now in the 2014 edition. How does that fit in these settings? We know it's sort of, if you will, the common subset for eligible hospitals and eligible professionals; how does that fit these additional settings? And then beyond that base, assuming that ONC goes forward with criteria specific to these care settings, what would be some kind of minimum necessary? What's the floor? We've generally looked at criteria to be as lightweight as possible. We've questioned whether in the end they were as lightweight as possible, but that I think really is the goal, to focus on what is absolutely critical in these settings. We've had a lot of discussion in the workgroup about unintended consequences, and so as we hear about these settings and their experience with technology in the settings and the experience that they may have with the current certified products, any insights they can give us into where the certification program has generated unintended consequences and where we might be able to mitigate or address those by how we go forward with certification in these spaces.

So I think that covers a lot of the ground that we've been over, over the last several weeks, and I'm really looking forward to the deep dive we're going to take today. I appreciate everybody's time and effort to get us here, and the time of the panelists and the workgroup members today because it's the holiday season; we should be out partying, but instead, we're having a different kind of party. So let's get on with the festivities.

Marc, anything else you'd like to add before we get started?

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

No, I think that's an excellent introduction, Larry, and I too appreciate everyone's time. It's a busy time for us all, so thanks, and I look forward to a good day.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay. Well, are we ready to begin?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Larry, this is John Derr. I think there's a word that we haven't mentioned so far, and that's that these are voluntary criteria. You haven't used the word voluntary, and I think don't people don't really understand or know that.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so yes. So I take that under advisement. So the certification criteria are voluntary, but we often know they get wrapped into programs where, while technically the program might be voluntary, the costs of not participating might be pretty high. So yes, these are voluntary, but we should also be advised that our goal is to encourage participation and so there's a balance in here, as well. Thank you, John.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

So, Larry, are you ready to get started with the first panel?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes, I am.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, so just a reminder to all of the panelists who are speaking, you will be limited to five minutes of oral remarks and I do have the unfortunate job of cutting you off, and I will cut you off at five minutes, so please be aware—apologies in advance.

So, our first speaker today on the first panel is—Larry, do you want to introduce the panel, or do you want me to?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Sure. Why don't we just, for consistency, let you introduce all the panels?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I'd like to say that some of these folks that will be presenting today are people that I and the workgroup have had interactions with in the past and welcome back. Many people are new to this workgroup and new to me as well, and so thank you again for taking the time to present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Larry. So the first panel is going to provide a clinical perspective. To speak on medication management, we have Shelly Spiro. On clinical decision support, we have Steve Handler. For diagnostic tests, we have Brian Yeaman—I don't believe he is on yet. And, from a public health perspective, we have Nimalie Stone.

So, Shelly, if you are ready, we'll get the presentation started and we will start your five minutes.

Shelly Spiro - Pharmacy e-Health Information Technology Collaborative - Director

Good morning. My name is Shelly Spiro. I'm the Executive Director of the Pharmacy HIT Collaborative representing over 250,000 of the ... national association and keep it involved in health IT. If the pharmacy HIT collaborative represents pharmacists in all practice settings, including LTPAC and behavioral health.

So the purpose of this testimony, LTPAC pharmacy settings need ONC HER certification support for voluntary adoption. From a clinical perspective, this support will assist LTPAC providers with improved medication management abilities. According to the 2013 ASPE report, pharmacists and pharmacies are ineligible for meaningful use incentives. Pharmacists play an important role in the interprofessional health care team in providing medication related services outside and in conjunction with prescription dispensing functions, and so when pharmacists are federally mandated by CMS to perform monthly medication regimen reviews or obtain the services of licensed ... to collaborate with other members of the interdisciplinary team. Pharmacists electronically assessing and exchanging clinical information in these settings—institutional qualities facing medication management processes.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I'm sorry—sorry, sorry—there's somebody who needs to mute their line. If everyone who is not speaking could please mute their line? Thank you. Sorry, Shelly.

Shelly Spiro - Pharmacy e-Health Information Technology Collaborative - Director

Okay. Over several years, the Pharmacy HIT Collaborative and its members have been working with NCPDP and HL7 on standards that will assist pharmacists with documentation of these patient care services required by CMS and private insurers. One such standard is a joint project between NCPDP and HL7 for consolidated CDA structured documents to meet CMS documentation requirements of an annual comprehensive med review. This structured document contains the pharmacist provided reconciled active med list, allergy list, indications for each active medication, and special instructions for the patient. The electronic structured document supports ... and SNOMED-CT codes. This CMS regulatory requirement went into effect January 1st, 2013 and includes residence in the LTPAC and behavioral health settings. Pilot testing of the use of the CMR in the community pharmacy setting should begin next year. NCPDP workgroup activity provides pharmacy industry guidance for CDA templates for pharmacy care notes and transition care documents. These standard CDA templates can be used by pharmacists and other health care providers in all practice settings including LTPAC and behavioral health.

In addition, the pharmacy HIT collaborative work with the NCPDP and HL7 and the development of a nationally accredited pharmacist DHR functional profile through the pharmacy HIT collaboratives workgroup activity and in preparation of voluntary certification, industry leaders are in the process of preparing guidance adoption of the standards in the community hospital long term care setting. According to a 2011 survey report by the American Society of Consultant Pharmacists, the QS/1, pharmacies are continuing to move more into automation, especially in large operation. Pharmacies surveyed have been the quickest to embrace e-prescribing automated packaging and electronic medication administration records. However, many are investigating ways to enhance their use in technology.

In terms of electronic prescribing in the August 2011, this provided a high level overview of NCPDP analysis of the use of script in the LTPAC setting. The document noted the consistencies in LTPAC prescribing adoptions, stating the lack of direction on the LTPAC e-prescribing standard has led to these inconsistencies, leaving a void of the vendor implementation in this setting. Since the exemption is scheduled to remove November 1st, 2014, the industry is unsure how lifting the exemption will affect the e-prescribing adoption in the LTPAC setting.

In addition, LTPAC settings have a higher use of controlled substances as compared to the ambulatory setting. Controlled substances represents further obstacles in the LTPAC e-prescribing adoption. The NCPDP LTPAC prescribing task group is currently working on a messaging process that would enable that workflow, protecting the e-prescribers medication orders while enabling facilities to review, annotate, and forward the order to the patient's pharmacy.

During the ASCP November, 2013 annual meeting, Rod Baird and myself presented a session on LTPAC e-prescribing model. The presentation outlined working models for the LTPAC physicians, pharmacists and pharmacies could use to meet the e-prescribing regulatory and standard requirements including those for controlled substances while using messaging standards to meet facility, staff and consultant pharmacist workflow and communication processes. LTPAC voluntary EHR certification programs can assist with improving medication management and ONC support for pharmacists and pharmacy EHR adoption is needed. We applaud ONC's efforts in providing industry guidance to pharmacists and all practice settings to voluntarily adopt EHR certification.

I thank you very much for letting me testify today.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Shelly, and that was perfect timing, so we appreciate that. I will now turn it over to Steve Handler. Steve?

Steven Handler – University of Pittsburgh

Good morning. Excuse me. Good morning, everybody. I'm Assistant Professor and Director of Clinical Informatics, the Department of Biomedical Informatics and Division of Geriatric Medicine at the University of Pittsburgh, as well as the Medical Director of Long Term Care Health Information Technology and UPMC Senior Communities. I greatly appreciate having the honor and privilege to speak to the audience about using clinical decision support in a nursing home setting. I'll speak to you from the perspectives of a geriatrician who provides care primarily in the nursing home setting, Certified Medical Director, an informatician, and a Health Services researcher.

My primary area of research is in the domain of medication safety in the nursing home setting and our research group has conducted a number of both basic and bedside translational informatics projects in this setting. It's this area where I believe that there is the greatest opportunity to rapidly develop, test, and disseminate clinical decision support systems that are consistent with the five factor framework previously developed and articulated by the Certification and Adoption Workgroup.

As a way of background, medications are used to palliate symptoms, improve functional stats and quality of life through our managed disease and prolonged survival. As many as 60 percent of nursing home residents prescribed over or equal to 9 chronic medications, which is the CMS definition of polypharmacy. The potential consequences associated with the use of medications is the development of an average drug event. Average drug events are defined by the Institute of Medicine as injuries resulting from a medical intervention related to a drug. These events are the most frequent medication related adverse event at approximately 2,000,000 average drug events per year, when you combine all U.S. nursing homes. They're also the most clinically significant medication related adverse event, and they're associated with approximately 93,000 deaths per year. This mortality rate equates to the finding of the seminal IOM report, "To Err is Human," where a comparable number of deaths were described to be associated with iatrogenesis in U.S. hospitals.

Finally, these events are the most costly related adverse events. They result in as much as \$4,000,000,000 of excess health care expenditures annually. Despite the frequency, consequence, and cost of average drug events, the current non-informatics based systems in place to detect and manage adverse drug events in the nursing home setting are inadequate.

Adding to this is that adverse drug events are difficult to predict as only the presence of polpharmacy, no other resident specific risk factor or characteristic has consistently been found to increase the likelihood of developing one of these events. Moreover, approximately half these events are considered preventable, and finally, most, about 80 percent, are associated with monitoring rather than prescribing errors, which is the opposite to what we see in ambulatory and hospital settings where most of these events are associated with prescribing errors.

Our research group has been working for nearly the past decade to develop, test, and assess the impact of clinical decision support systems to detect and manage adverse drug events in the nursing home setting. The systems that we've developed use signals that require the presence of admission, discharge, transfer, lab, and medication data. We're in the process of completing a randomized control trial funded by the Agency for Health Care Research and Quality, or HRQ, assessing the benefit of an active medication monitoring system and average drug event detection and management in this setting.

Since my own health system does not have an EMR, we have worked with MDS laboratory and medication service providers for a current clinical decision support system to work. It is my goal this morning to further reinforce the value of a voluntary LTPAC EHR certification program and specific certification criteria so that my organization and others can ensure that they have EMRs that meet a minimum set of agreed upon requirements. Specifically, I am in support of the base EHR definition, ONC 2014 edition and certification criteria, which is inclusive of requiring clinical decision support as a core requirement. I believe that the five factor framework proposed by the Certification and Adoption Workgroup validates the need for inclusion of clinical decision support as part of any LTPAC EHR certification program and specific certification criteria. I will use AD detection and management as a use case for this discussion, as I've been doing so, but there are many additional examples of how clinical decision support rules can benefit residents in the nursing home setting.

As it relates to the five factor framework, one is to advance natural priority or legislative mandates, medication safety as an NQS, IOM, and IHI priority. In terms of aligning with existing federal and state programs, the current federal regulations require consultant pharmacists to review each resident's chart on a monthly basis and determine if medication related problems are present, such as the presence of adverse consequences. This is known as F-Tag 428. We believe that CDS can greatly improve the detection and management of these problems and improve F 428 and inclusion of medication specific CDS should provide alignment with and support existing federal and state programs.

In terms of utilization of existing technology pipeline, there are existing standards for lab, including LOINC and medications, NCPDP, and are widely available to support this safety system. The rules engine, however, do not have existing standards. If we want to build on existing stakeholder support, it seems logical that medication specific CDS would create safety and efficiency gains as well as support QI and federal and state programs. Then finally, to appropriately balance the cost and benefits of the certification program, I believe that medications specific to CDS would likely be more cost effective than using manual techniques and insurance had been cost neutral or cost beneficial in other clinical care settings.

In summary, I believe that there is a significant need for the inclusion of clinical decision support as part of any LTPAC EHR certification program and specific certification criteria. I hope that my attempt—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay. Thank you, Steve; your time is up. I'm sorry.

Steven Handler – University of Pittsburgh

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Brian Yeaman, I believe you're on now; I don't think you were on before. As a reminder, you have five minutes. Are you there, Brian?

Brian Yeaman, MD – Chief Medical Informatics Officer – Norman Regional Health System

I'm here; I'm here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay. Go for it.

Brian Yeaman, MD – Chief Medical Informatics Officer – Norman Regional Health System

Okay, thank you. This is Brian Yeaman. I am a family medicine physician in Norman, Oklahoma at the Norman Regional Health System, and I practice family medicine in a clinic setting. I'm also the principal investigator on the Oklahoma Office of the National Coordinator Challenge Grant, and our efforts specifically, of course, we're looking at how we move patients from long term care to acute care and back, and—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

If there is somebody that has their computer speakers on, if you could please mute that. Sorry, Brian.

Brian Yeaman, MD – Chief Medical Informatics Officer – Norman Regional Health System

No problem—so we were looking at how we move patients from acute care to long term care and back, and essentially, we have a well deployed health information exchange. We have a good infrastructure, but then the health systems in a good infrastructure for electronic health records within the inventory setting, and of course our topic today, the penetration of technology into the long term care setting is widely varied and, as the deployment of these systems is of course inconsistent and what we have, of course, found here in Oklahoma is that the consistency of how things such as decision support as you've just heard about are applied and how things such as health information exchange are applied and then even just simple tools such as universal forms for transfer or any type of common communication or standard communication about the patient's status or condition when they are transferring from one set of care to another is very inconsistent.

Frequently, what we found is that the emergency department does not know why the patient's been transferred from long term care and what is being reported by EMS is frequently inconsistent with why that patient was exactly transferred. Our application of a lightweight electronic health record with decision support standards built in that enable a clinical nursing assistant, a CNA, to the highest level of their license, essentially creating real time documentation within the long term care setting allowed for intervention and application of decision support rules, those decision support rules did early alerting if a patient was changing status and allowing us essentially to intervene earlier if the patient was changing status and potentially avoid a readmission or a primary admission or a return to the emergency department.

In addition, we applied standards within the lightweight electronic health record and how we were transferring information into the health information exchange that was viewable in the acute care setting, and then of course viewable in the long term care when the patient was returning from acute care. The information that was transmitted from nursing homes included activities of daily living, but also ambulation status, cognitive status, and baseline information for the patient and then of course the information for the patient at the time of transfer.

One of the most powerful interventions, though, that led to our results of this grant that we have been conducting, of course, is the use of direct, which is HIPAA compliant e-mail, essentially, and the utilization of the SBAR, and the SBAR is Situation Background Assessment and Report. The standardization and simplification of this SBAR report and the usage of that when a patient is moving from long term care to acute care and then of course back from acute care to long term care is what I like to call the need to know message. It's the one liner about, "What's the most important thing you could do for this patient at this time?" That information is then flowing from the long term cares to the acute cares, as in using a paper format early in the project, it's transmitted via direct at this time.

As we've matured the process, we transmit it via the health information, and that information is widely adopted, widely praised by the providers at the bedside. They have a recognition of what is occurring with the patient, why the patient has presented frequently. These patients have altered mental status, they have an inability to report a lot of their history. They may show up at the emergency department. That confusion factor leads to admission, working up the wrong diagnoses, prolonged length of stay. As we evaluated that information and we got better at crossing the SBAR with the information in the health information exchange, the acute care providers are able to more easily identify and reduce readmission.

Also, with the lightweight EHR, we've been able to reduce return to the emergency department by 40 percent. We've reduced 30 day readmission by 30 percent—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Brian. I'm sorry; your time is up.

Brian Yeaman, MD – Chief Medical Informatics Officer – Norman Regional Health System

Yep; thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Uh huh; thank you. Nimalie?

Nimalie Stone, MD, MS – Centers for Disease Control and Prevention (CDC)

I'm here; sorry. Just taking myself off mute.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, thank you.

Nimalie Stone, MD, MS – Centers for Disease Control and Prevention (CDC)

Okay, good morning. My name is Nimalie Stone, and I am the Medical Epidemiologist for Long Term Care for the Division of Health Care Quality Promotion at the Centers for Disease Control and Prevention.

Thank you for the opportunity to share the public health perspective on the importance of defining health IT standards and an EHR certification process for LTPAC providers.

As I was preparing for this presentation, I considered two key questions. Number one, how could an EHR certification process for LTPAC providers address public health goals; and number two, which clinical data should be prioritized during the development of health IT standards to meet public health needs? To answer the first question, it is helpful to consider the three core activities for public health: Health surveillance, prevention, and policy development. Success in each of these activities relies on having data for action, whether caring for a single person or an entire population, the availability of timely, accurate, and valid information is critically important to decision making. Therefore, establishing a common language for recording and sharing clinical data could dramatically improve the flow of information from health care providers to one another as well as to public health entities. Within the five factor framework defined by this working group, advancing national priorities and alignment with existing federal and state programs are important considerations during the development of the new EHR certification process.

Let me provide one example of how bringing EHR certification to LTPAC providers would support other national initiatives. In 2009, the Department of Health and Human Services established a national action plan to prevent health care associated infections or HAIs. This plan has been establishing infection prevention priorities and metrics for health care settings, from acute care hospitals to long term care facilities over the past four years.

Starting in 2011, the Centers for Medicare and Medicaid Services Quality Reporting Program added the reporting of HAI data into the CDC's National Health Care Safety Network, which is a national HAI reporting system as a requirement for certain payment incentives. In 2012, the HAI reporting program requirement was extended to long term care hospitals and acute inpatient rehabilitation facilities, which began reporting data to CDC in January of this year. As these reporting programs expand, creating the capacity to identify HAI events within EHR systems and transmit data to CDC using interoperable exchange would reduce the burden of data collection for facilities while standardizing the data submission process for all providers.

Now, let me briefly try to address the second question: Which clinical data should be prioritized during the development of health IT standards to meet public health needs? This is a much longer discussion than we have time for today; however, I believe there are at least two areas which are priorities from a public health perspective. They are medication administration data and laboratory data. Given that the focus of my division is on HAI prevention, let me illustrate specific examples of how information in these areas would align with our priorities. Medication administration data on immunizations and antimicrobials would support our efforts to prevent the transmission of vaccine preventable diseases and reduced the emergence of antibiotic resistant organisms.

Results from molecular, diagnostic testing, and microbiologic studies which identify infectious diseases are vital to several of our infection surveillance initiatives. To provide a timely example, defining a health IT standard for electronic capture of influenza vaccine administration across providers would enable this information to be exchanged between health care providers as well as with state vaccination registries. This could reduce duplication of immunization efforts among different health care providers caring for the same person, reduce that individual's risk of receiving multiple vaccinations within a single flu season, and provide public health with reliable information and vaccine coverage within communities or regions.

As I mentioned, these examples reflect the priorities for my division and Center; however, other partners in public health would probably add to the list of clinical data elements which would be vital for supporting their program goals. Let me conclude by thanking the HIT Policy Committee for considering the needs of public health entities in this process, and for the invitation to participate in this exciting discussion. I suspect we have only scratched the surface in identifying the opportunities and benefits to enhancing data exchange between the LTPAC providers and public health, but it is very clear that increasing this capacity will only improve the flow of information at the intersection between public health and health care, and improve the care provided in our communities. Thanks.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Nimalie, and thank you to all of our speakers on channel one. We will now open it up to questions from the workgroup. As a reminder, there is a “raise the hand” icon that you can click if you have any questions and you want to get us started.

Paul Egerman has a question.

Paul Egerman – Businessman/Software Entrepreneur

Yes. Thank you. First of all, I want to thank all of the panelists. This is extremely informative and I appreciate your presentations, and had a question for Steve Handler. If I understood you correctly, you said that unlikely ambulatory settings, in your setting, monitoring errors are more prevalent than prescribing errors, and so I got the impression that prescribing errors are less of a challenge, and so my question is, does that mean that e-prescribing functionality is also less important?

Steven Handler – University of Pittsburgh

That's a great question. There has been two large studies, both done by Jerry Gurwitz, to define specifically what part of the medication use process was associated with adverse drug events. In the biggest study, they found it was monitoring errors. In the second study, they found that it was monitoring errors also, but very closely tied with prescribing. It's kind of neck and neck.

So I don't want to make it seem as though, that prescribing errors are not as important or not an important area to work with. Out of necessity, based on my own health system and research laboratory, so to speak, since we didn't have an electronic medical record nor a way to provide clinical decision support at the time of prescribing and using the literature to support our approach, we chose to focus on medication monitoring. However, that does not lead me to conclude, and I don't want to mislead the group to feel as though that prescribing decision support in nursing homes would not be incredibly valuable. However, with some caution, the very few studies that have been done in the long term care setting that have been done primarily at the prescribing point, one focusing on medication prescribing for primarily renally dosed drugs and others that focused on a variety of providing information about Beers List Criteria drugs and other things like that, and a couple other studies have not really shown any benefits in clinical outcomes, but have shown improvements in process outcomes.

So I guess the bottom line is that we have a lot more research that needs to be done. I don't want to dissuade or discourage the use and development of prescribing decision support, but in the nursing home, it's important to remember to focus on monitoring as well, and that's one of the key points I wanted to make in the presentation.

Paul Egerman – Businessman/Software Entrepreneur

And that's helpful. It seems consistent with, at least in general, what I think I heard from Shelly Spiro or Spiro, I don't know if I'm pronouncing her name correctly—but basically, in her testimony, she first talked about the monthly monitoring process, and then towards the end she talked about e-prescribing. So I sort of inferred from that, that the monitoring is where the priority is, but that e-prescribing is less important but still important. Is that correct?

Steven Handler – University of Pittsburgh

I don't know if I'm going to want to characterize that. I just, I have not done the research. There's only really been one study about, formal study sponsored by HRQ for e-prescribing in the nursing home setting. There are companies that provide e-prescribing services in the nursing home. I'm unaware of them looking at resident specific outcomes or even many process measures, for that matter.

What I don't want to do is start a debate about which place to fix. Sort of similar to quality improvement, I found the first place to start working, and I want to improve it; another person could start with prescribing. They all need to be done. The point of my testimony was, let's please include clinical decision support, providing a use case where I think it's valuable, but many others exist and I do believe that prescribing decision support would be very valuable in this setting if done correctly.

Paul Egerman – Businessman/Software Entrepreneur

Thank you; very helpful. So, following up on that—this is Larry Wolf. Since we're talking about prescribing; Steve, you mentioned that these patients generally all meet the profile for polypharmacy, so it seems to me that that would tend to address some of the concerns that you've suggested to say there's not research in support of needs for guidance on the prescribing side as well.

Steven Handler – University of Pittsburgh

That's the only consistent patient or resident level characteristic that has been associated with adverse drug events, and it makes sense. The more medications you take, the harder it is to monitor; the more drug-drug interactions there are; the more potential use for potentially inappropriate medications and oftentimes we don't even know, when we receive residents in the nursing home, why are they on the medication to begin with? Physicians and pharmacists have a reluctance to sometimes peel back and remove medications, but oftentimes that's the most rewarding part of medicine is actually exposing the person underneath all the side effects and the adverse drug events that are occurring.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Nimalie, do you have a comment to make as well?

Nimalie Stone, MD, MS – Centers for Disease Control and Prevention (CDC)

Yes, thank you. I would just add that, depending on the class of medications being considered, the level of opportunity for using clinical decision support at the time of prescribing can be quite significant. For example, there is a clear opportunity to optimize the way antibiotics are being used and other antimicrobials—not just in the LTPAC setting, but across all health care settings. Quite a bit of the antibiotic stewardship literature from acute care hospitals would suggest that clinical decision support at the time of prescribing is one of the most powerful ways to change or influence physician and provider decision making. So I would just second the importance of looking at ways to integrate decision support at the time of e-prescribing.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Nimalie. Larry, you had a question; was that your question, or do you have an additional question?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I have a couple of questions. So, related to the pharmacy, Shelly Spiro and her comments gave us a fire hose of information, but something jumped out at me that maybe is a role that exists in nursing centers; specifically, the role of the consulting pharmacist, and I just wanted to point that out and maybe she had a couple of comments about both the monthly and annual comprehensive med review and the CA document that she says is being developed give us a sense of—so where is that? Is that still pretty early stage in terms of the technology and the specifications, or where are things with the testing?

Shelly Spiro - Pharmacy e-Health Information Technology Collaborative - Director

This is Shelly Spiro, and I do pronounce my name Spiro, like Spirograph. Thank you, Larry, and I did want to comment on the previous question, too. We do, especially within the pharmacy environment, both in the ambulatory settings, hospital and long term care settings, the focus on monitoring medications. What electronic prescribing or even adoption of EHR in connecting the pharmacist with facilities and the ... and the other health providers as part of the health care—the important piece is having the information real time.

Right now, and in a manual environment, there is a huge time lag that takes place that Steve Handler had talked about earlier in terms of some of the errors that we find. As we go to bidirectional exchange of information and the information becomes more real time, we can close those gaps on adverse drug events. Because what happens, medications that are available to the patient and we can't connect the pharmacist with monitoring those medications fast enough in order to prevent those errors. So we believe that in adopting electronic health record and technology in the LTPAC setting will help decrease the adverse drug events and also clinical decision support.

In terms of answering your question, Larry, on where we are with clinical documents, especially structured documents, the HL7 standards, we are—we have done all the work that we can in terms of standards development work. We are working with our industry leaders in trying to create pilots in relationship to medication therapy management. Most of that is occurring in the community pharmacy setting, and also between the community and hospital setting, and this is mainly because those two settings are—especially from the physician and from the hospital standpoint, are receiving incentives for meaningful use, and they are already adopting electronic health record.

Because we don't have the adoption in the LTPAC setting, we don't have these really ... types of communication available. The Pharmacy HIT Collaborative works very closely with our vendors and with our providers, especially on the pharmacy side, to have these consolidated CDAs available—transitions of care, for progress notes, and also for meeting the requirements of the comprehensive review, which is a Medicare Part D requirement, which the majority of patients in long term care or a traditional skilled nursing facility is, a very large percentage of those patients fall into that category, even if they are in a Medicare Part A stay, if they are a Medicare D beneficiary, they're still going to run into receiving the requirements of MTM, because they were not exempted from that requirement under the Medicare Modernization Act.

So we are working as quickly as we can to try to get places to adopt—we do have a few site locations that are beginning to work on adopting consolidated pay. Some of those are payer to our MTM intermediaries. The beneficiaries are beginning to use the consolidated CDA and the clinical information, breaking it open and using that instead of some of these flat files of information that are being transmitted. CMS, through the Medicare Part D program, has been very responsive in their regulatory process promoting and encouraging plans to use the consolidated CDAs. We are open to help any of—that's part of the objective of the Pharmacy HIT Collaborative is to provide technical support to any organization that would like to pilot test any of the documents out of NCPDP and HL7.

Brian Yeaman, MD – Chief Medical Informatics Officer – Norman Regional Health System

This is Brian Yeaman. I'd like to also comment that we are back to that consolidated CDA between our acute care facilities and our long term care facilities. What is extremely relevant—unfortunately, I didn't get to that in my presentation, but the passage of the diagnostic testing, the information related to laboratory results or any sort of imaging results, many of these patients have renal impairment or some type of liver impairment and those factors, and knowing those lab results, are extremely critical at the time of prescribing, many of the medications that we use and many antibiotics require renal dosing or contemplation of any liver impairment in terms of their dosing.

If those factors aren't able to be monitored in a timely fashion or they're not, that information is not available to the prescriber, that leads to many adverse events. So having that information available is extremely important, and I would comment that the e-prescribing and the need for CDA and EHR within the long term care facilities really all go hand in hand. It otherwise treats a chicken and the egg sort of scenario where if you apply just one intervention without a complete complement of tools for the prescriber in the long term care setting, return will be really relatively low versus having a full complement of tools.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Thank you. Thanks, Brian and Shelly.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Larry, I—sorry. Go ahead, Larry. *[Laughter]*

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

See, I had a—this is John. I had a question. Is our hand raising thing working, or—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

It is. I was just going to go to you, John.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

My question—and thanks a lot for the panel and everybody else that's been on this. Mine was to Nimalie. Shelly and I, as pharmacists, were just at the ASHP meeting, and I talked to a couple software companies that were monitoring infectious diseases within the hospitals, and I asked them how they got that information to nursing homes and home care agencies and all that, because we would like to know whether somebody had an infectious disease within the hospital, and they said they don't, that they don't transcribe that information to anybody, it just stays in the hospital pharmacy. I was wondering whether you were working on that type of thing, because we would really like to know that in our transitions of care information.

Nimalie Stone, MD, MS – Centers for Disease Control and Prevention (CDC)

Hi; thank you for that question. I completely agree that having those pieces of information identified and communicated across care transitions is incredibly important. I can speak to the, I mentioned the National Health Care Safety Network, which is a national infection reporting data system that is managed by my division here at CDC.

One of the types of events that a facility can report into the system are positive laboratory identified multi drug resistant organisms; for example, methicillin-resistant Staphylococcus aureus or vancomycin-resistant enterococcus or even C. difficile. The presence of colonization or infection with those organisms is incredibly important for any receiving facility to be aware of so that they can ensure the safest placement and safest care being delivered to that person. You're correct that currently we don't see very effective communication of those entities across, from a care, the long term care providers. We are promoting the reporting of those events from both care settings so that there will be a mechanism potentially for facilities to be more aware of when those organisms are occurring in their patient population so that they have ready access to share that information at the time of transition, but this is a very good example of how setting standards for identifying, documenting those particular infections could be very valuable for information sharing.

Steven Handler – University of Pittsburgh

If I may just—yeah, sorry, if I may just speak up?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Sorry—go ahead, Steve.

Steven Handler – University of Pittsburgh

Sure, sorry—I just wanted to follow up on that. So, in our organization, as you heard during my testimony, we do not have an electronic medical records system; however, we do have a clinical surveillance system that is across all of our clinical settings, including ambulatory, acute care, and nursing home care. We use this system for infection prevention, control, for HAI detection management reporting, and it does allow us to exchange information about HAIs or multi-drug resistant organisms and communicate that to the next care setting.

However, that exists outside of an electronic medical record, per se. It could be used as one, but it's not. I just want to make that aware, that there are other systems which may be beyond the scope of this meeting today, but that could work to transmit this information from setting to setting, and that's the same system that we use, for example, for adverse drug event detection management, and that's why we're able to do it outside the purview of an EMR. However, we all, collectively on this call, would like to see that in an EMR, not as a standalone feature, application, et cetera.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr. As a follow up, it was just amazing to me, I asked these two different companies whether they were transmitting that information into the EHR and it was like, "Why would we ever do that?" I just was very surprised of that somewhat noncooperation in the transitions of care, and that's where the knowledge has to be where we start training these people in the hospital that we are part of the spectrum of care and not just keep them as silos.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Jennie Harvell has had a question.

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging & Long-Term Care Policy

Thank you very much, and I also want to thank the panelists for a very excellent presentation, very filled with a lot of great information; thank you very much.

I was wondering if any of the panelists had considered whether the criterion in the ONC 2014 edition could support the functionality that each of you described as needed in the long term post-acute care settings in terms of e-prescribing, clinical decision support, medication administration, and lab result information in content needed to support transitions of care. Thank you.

Brian Yeaman, MD – Chief Medical Informatics Officer – Norman Regional Health System

This is Brian Yeaman; I can comment on that. I do believe that some of the standards that are currently applicable in the ambulatory and acute care setting for meaningful use could be applied to long term care. I think we have to be somewhat judicious in terms of how we are applying those and to the extent that we apply them, but some of the relevant factors—and I think all the panelists have brought these up—the elements of e-prescribing, the transmission of the diagnostic data, and information such as the activities of daily living, the clinical surveillance data, the passage of that in a CDA and the participation and health information exchange in direct I think is very applicable, of course, and of the wider based installation of the electronic health records and how this information is transported and represented to a provider and consolidated views at the time of making decisions or monitoring a patient or, of course, by prescribing.

All of these factors, I think, are extremely relevant in a long term care setting. Do I think that we could implement all of those rules—no, but I do think that there is a subset of those that would be highly relevant and would make an immediate impact in the setting once they're implemented.

Steven Handler – University of Pittsburgh

And this is Steve Handler. To follow on that, Jenny, with regard to the base EHR definition, the 2014 edition that you provided to us prior to this meeting this morning, I concur and agree with all of the components. The question that I would have back to you and to the group would be, how prescriptive—sorry to use that word—do we want to be with regard to clinical decision support? That is, do we want there to be a certain type of clinical decision support or focus of clinical decision support based on, perhaps, the events or types that are most egregious, costly, harmful, et cetera?

There will be an Office of Inspector General report coming out in the next month that will define the base rate of harm events that I was involved in in nursing homes. I'm not at liberty to share the results, but that may be something that we can drive or link our CDS rules to. That is, we should not make it just open ended that any CDS rule can be written; however, we should try and link it to those harm related events to try and reduce that, but that is a suggestion. But perhaps making this a little bit more granular but on face value, all of the base definitions for this base EHR make complete sense, and I think there's probably consensus amongst that. The question is, how do we take a deeper dive? Can we take a deeper dive? Should we take a deeper dive? Should that be linked to any other research or data that's out there on other events, and how can we make a difference? How can we move the needle, so to speak?

Shelly Spiro - Pharmacy e-Health Information Technology Collaborative - Director

Well, this is Shelly Spiro. I do want to comment especially—thank you, Jennie, for some of the work you're doing on the prescribing, and I think a lot that you're aware of do have some issues in relation to the LTPAC setting on e-prescribing, especially with controlled substances. The DEA regulations just do not meet the requirements for the three way communication that we need between the facility, the physician, and the pharmacy. We do have some regulatory issues in relationship to e-prescribing.

Also, I talked to some of the larger e-prescribing intermediaries or in the network such as, as an example, Surescripts or Emdeon. The model, the payment model is just not there, or the reimbursement model for those are just not there for the long term care setting and that's the upwards adoption. Hopefully with ... we'll begin to see the adoption in e-prescribing.

I truly believe that e-prescribing just as we saw within the adoption they charged in the hospital and the ambulatory setting can be a driving factor to increase adoption. There are certain advantages of e-prescribing on the physician's side, on the pharmacy side, and also in improving patient care. So, using that as a stone to help adoption reporting, that's one of the reasons why, through the Pharmacy HIT Collaborative and the American Society of Consultant Pharmacists, we work very diligently in this area of long term post-acute care to work with adopting e in this setting.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Shelly, and with that, we're going to have to turn it over to our next panelist. So thank you very much to everyone on panel one; we appreciate your thoughtful insights.

So now, panel two will also be clinical perspectives. We have Terry O'Malley from Partners; Laura Tubbs from the Southwest LTC Management Services; and Lauri Harris from Avalon Healthcare. So, Terry, if you are ready, we can start with you. As a reminder, you have five minutes. Are you there, Terry?

Terrence O'Malley, MD, Medical Director for Partners HealthCare

Yes, I am. Thank you very much, and thanks to the committee for their incredible work on an ongoing basis.

I'm an internist and geriatrician and I spend half my time providing post-acute care to individuals at a high intensity skilled nursing facility, and the rest of the time I spend on transitions of care and the integration of care within a Pioneer ACO, and in my other job working with ONC and the S&I framework, HL7 and the impact challenge grant to define and standardize some of the essential clinical information needed to support transitions and longitudinal coordination.

I'm going to try to touch on three pieces, sort of the why, what, and how of EHR certification for LTPAC, and the why really falls, I think, to the fact that health care has fundamentally changed in the last 40 or 50 years and will continue to change as our population ages and as individuals accumulate an increasing burden of chronic conditions. So instead of brief encounters with the health care system for acute illness, more and more individuals have and will have episodes of acute illness superimposed on chronic conditions, and the result is far more complex care provided in multiple sites by multiple clinicians across longer episodes of care.

This is only going to increase as the population ages, so with these individuals, what becomes really important for them are really two fundamental health care processes, and the first is the transition of clinical responsibility from one clinician or clinical team to another, and with the information required to safely and efficiently exercise that responsibility, that's a transition of care. The other is—and each exchange, from site to site or team to team is a transition, and each level of increasing clinical complexity generates additional transitions as acute conditions are superimposed on more and more chronic conditions, and each combination requires more persistence and more sites of care and failed transitions are a leading cause of adverse events and avoidable costs. The second process is the exchange of a longitudinal care plan to align care across these multiple sites and providers and reduce the risks of omissions and duplications. Certainly, failure to coordinate care results in frequent avoidable adverse events and billions of dollars in avoidable costs.

An LTPAC EHR certification would set the foundation for these two essential processes. In the 2012 Medicare Chartbook, there are 14 percent of Medicare beneficiaries who have 6 or more chronic conditions, receive care at multiple sites from multiple, often unaffiliated providers, and they experience many transitions of care and they account for 46 percent of all Medicare spending, 70 percent of 30 day readmissions, 70 percent of one or more ED visits, 63 percent have one or more hospital admissions per year, and importantly, 41 percent go on to receive LTPAC care. In fact, the total amount spent in LTPAC for these patients, this 14 percent, exceeds the amount spent on acute hospital care, but because of their complexity and the ... of multiple providers and care in multiple sites, these patients are at highest risk for failed transitions and poorly coordinated care, and this I think is why we need certification.

The what is a little different, but both transitions of care and care coordination require the exchange of essential clinical information, but very few LTPAC providers share a common EHR platform with their acute partners, nor is it likely that this will become a widely adopted model. It's far more likely that LTPAC will share care with several acute care partners, all using different IT platforms. The electronic exchange of standardized, interoperable clinical information between different IT platforms becomes the essential tool for care integration between and among acute and LTPAC providers.

In my opinion, the benefits of EHR certification is primarily to support the interchange between different sites of care rather than promote efficiency and even safety within each site of care. I think the benefits are greater to look at improving the exchange. That's why I hope that will become an important goal for certification, and we now have the data elements that can serve as the national standard for transitions and longitudinal coordination of care. The HL7 is the main analysis workgroup; the ONC longitudinal coordination of care, ASPE, and many others have completed the final stages of HL7 ballot reconciliation and these data elements, which will be available for reference early in 2014 and at a minimum, EHR certification for both eligible providers currently and LTPAC sites should include the capacity to send and receive these standardized data elements to support transitions in coordination.

Finally, the how is the real big question. It's not clear what the business case is for LTPAC to adopt this, and it's unlikely that the ACOs will be a sufficient driving force to pay for their adoption. There needs to be some other business model in place, and it may ultimately have to rest on quality metrics that incorporate—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Sorry, sorry; your time is up. Thank you very much.

Terrence O'Malley, MD, Medical Director for Partners HealthCare

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Laura Tubbs, are you available?

Laura Tubbs, Southwest LTC Management Services

I am.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay; go for it. *[Laughter]*

Laura Tubbs, Southwest LTC Management Services

All right, great. Thank you for the opportunity to speak today on this panel. I'm the VP of Clinical Services for Southwest Long Term Care Management, and I'm committed to centralizing our clinical platform and deploying our electronic health record. In the past, I was Director of Clinical for the Evangelical Lutheran Good Samaritan Society, which was a 186 facility non-for-profit provider, and assisted on the electronic health record development team for approximately 4 years.

My talking points for today are about the long term care basics, the must haves that make us unique to our industry. We have to have our reimbursement piece, the MDS, as part of our electronic health record. We also have to have a regulatory component that CMS requires us to document and for surveyors to filter through during the survey process, so CMS reports as well that are required and standardized for the surveyors to review and we also have our ICD-9 coding. Documentation that follows are our state operations manual, Appendix TP related to survey requirements, and resident's condition, including Medicaid and Medicare charting guidelines on top of our regulatory documentation. Medication administration, treatment, user defined assessments, and individualized care plans all fall under that umbrella. Then we also have our state regulation nuances as well that may require more documentation.

So currently, gaps in the system that cause one to pause is, the RAI manual currently has some changes that can affect the electronic medical record system with no turnaround time. So the government pushed out the changes, and then the vendors have to create opportunity for that system to integrate. It doesn't always happen in a timely manner. There's gaps due to lack of that turnaround time, so specifically, recently, the RAI manual was updated in Section G with ADLs. The thought process with that is that they wanted the cross referencing of therapy documentation along with some interdisciplinary review and comment during the seven day look back period. This causes a gap because the electronic health record currently doesn't do a cross matrix for matching of those and the therapy documentation usually is narrative, so there has to be opportunity to change that and pull through. It just becomes cumbersome for the end user, who has to then data mine from two different systems.

So, that being said, that's just one example. Consistent formatting of certification is needed within the industry that allows for a turnaround time for IT to make those changes related to documentation and coding. As the volume and pace of clinical, regulatory and electronic health record changes continues to increase, so does the need to ensure the health IT systems are adequately prepared to implement these changes while post-acute and long term care providers are excluded from electronic health care record meaningful use incentive program, the clinical and regulatory changes being made still have a significant impact to these providers and requires a sophisticated implementation to successfully integrate into, it's critical that CMS standardize implementation guideline timeline and require the post-acute long term care health IT systems certify that they are prepared for documentation of these changes. It is widely known that there is a lack of interoperability and standardized information exchange between health care providers, disciplines and systems.

So regardless of what avenue CMS takes in respect to reimbursement and clinical outcomes monitoring, there's a strong need for CMS to adopt a minimum criteria for standardized patient health record information to be utilized across all providers and disciplines. That concludes my speech.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Lauri, are you all set to get started?

Lauri Harris, RN, Avalon Healthcare, Inc.

Yes, I'm here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Please go ahead.

Lauri Harris, RN, Avalon Healthcare, Inc.

Good morning, ladies and gentlemen. My name is Lauri Harris and I'm a Registered Nurse. I've worked in the post-acute care environment since 1989, so I feel like I've seen a lot of changes over the years in post-acute care. I currently work for Avalon Healthcare, which is headquartered in Salt Lake City, Utah. My position here is the Director of Clinical Applications, and my primary responsibility is the implantation and subsequent support for the electronic health record throughout the division of cardiac facilities in five states. We provide skilled and long term care to upwards of 3000 patients a day and employ approximately 5000 care givers in our mission to embrace a reverence for life and a heart for healing.

I wish to touch upon three items in the few minutes that I have to address this workgroup today. One, integration of a total solution; two, improvement of the quality of patient care with a couple of specific examples; and the prevention of re-hospitalization. Integration of a total solution, meaning clinical, billing, therapy, and pharmacy programs must share information to build quality and cost effective care in the post-acute setting. The need for integration is unique to post-acute care. Many people think that hospital or ambulatory care software platforms work for the post-acute environment—this is not true.

One important consideration that I wanted to add to my comments today based on some information that I was just listening to as I was hearing other testimony is that it's important for us to remember that most of the data entry done in long term care is completed by nonprofessionals. The electronic health record is critical to improving quality of care, and I offer the following examples. Number one, interoperability. As the patient experiences care transitions, interoperability will lead to efficiencies not previously seen in the post-acute environment. Avalon is embarking on a project in 2014 that we anticipate will result in saving two hours per admission and facility staff time alone. This savings will be realized because of the automated entry of appropriate orders which have been electronically delivered from the discharging hospital into the SNF EHR. This will also decrease keystroke entry errors, which today frequently contribute to patient harm. The time saved will allow staff to focus efforts on improved data gathering and evaluation of the patient's condition which is critical as sicker individuals are admitted.

I think some of the difficulties that we hear today are that the definitions of similar terms differ across care settings—for example, the definition of minimal assist with ADLs. In a therapy environment, minimal assist means something very different than in an RAI process when you're trying to gather information and you're trying to make decisions about the patient's actual condition. The entry of patient information into software allows for readable records which are accessible to multiple departments within a facility concurrently. This can provide for improved care within the SNF environment, which is delivered timely with consistent and complete subsequent documentation of events.

I believe that the EHR can also improve compliance with company guidelines because of the uniform structure that can be provided to staff, many of which are nonprofessionals in the completion of their daily tasks. This is augmented by the ability to create notifications and alerts that provide system generated information to supervisory staff in real time regarding patient conditions, which allow interventions to be implemented before serious consequences are realized.

Number three, the EHR can be instrumental in reducing preventable re-hospitalizations which will save millions of dollars for the health care system, and I'm offering two examples. In the reduction of medication errors, I believe the practice of prescribers entering orders electronically into the EHR will decrease the chance for errors in the interpretation of prescriber orders. Now, we heard today earlier that monitoring was more important than prescribing; however, in my experience, a significant number of orders are changed today verbally or via telephone, which result in SNF staff entering the order into the software rather than the prescriber doing it. Therefore, keystroke errors are frequently identified in our business as contributors to adverse events that result in patient harm.

I also believe that the provision of CarePass and industry approved standardized tools which are research supported improve the ability for staff to implement interventions earlier and contribute to timely physician notification as changes in condition occur. An example is, by abetting the INTERACT III system for staff utilizing the identification of changes in patient behavior, appetite, and/or routine which can reduce the need to transfer to the hospital. To conclude—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Lauri; your time is up. I'm sorry.

Lauri Harris, RN, Avalon Healthcare, Inc.

Thank you. No; you're fine.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I will now open it up to the workgroup members for questions, and John Derr has a question.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Hi. Thank you very much, panel. That was excellent. I want to ask Terry O'Malley—I hear an echo, here—Terry, would you be able to, you and I have worked on eQuality Measures. Would you comment on how minimal certification might help in doing eQuality Measures across the spectrum of care?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Terry, before you answer, I'm sorry—if others could please mute their line, and if you have your computer speakers on, please mute your computer speakers. Thank you.

Terrence O'Malley, MD, Medical Director for Partners HealthCare

Okay. John, thanks for the question. eQuality Measures is a fairly broad topic, but let me—I'll focus on a tiny piece of the eQuality measures, which I understand to really be using the exchange, the electronic exchange of health information as part of care and simultaneously using those as a quality metric. I think that the certification requirements for LTPAC, if they were to include, say, the functionality, the ability to exchange the interoperable data elements required for good transitions and the longitudinal coordination of care in and of themselves, just that capability and whether people exercise this could be a quality metric that could drive some of the adoption of the EHR, but also fundamentally improve the process of care. It's kind of a nice twofer. You're improving care and oh, by the way, you can use it as a quality metric. I hope that answers your question.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Yes it does, Terry. Because that's—often, I have felt that a lot of the quality measurements are sort of penalty quality measurements rather than improving clinical care. That's what I think you were talking to; thank you very much.

Terrence O'Malley, MD, Medical Director for Partners HealthCare

Okay.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay. Paul Tang has a question.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yes, thank you. Thanks for this panel and also to the previous panel. I guess I've been hearing a lot of compelling reasons why it's very useful to have information to go to and from LTPAC. I mean, it just rly has to go through the entire enterprise.

What is a little bit less clear—and I think Terry alluded to this—is what, if there was a certification program that's voluntary, what's the business driver that would cause it to make a difference? I wonder if people could just give their opinion about that. If the program existed, what would drive the changes that you seek? Remember that both the systems have to exist and the people have to use them, and I think it was John Derr that said, “Well, you guys, why would we even want to put it in EHR?” was one of the comments that he heard. So we have to have both the systems and the motivation and behavioral change. So what would cause that if the program were to be put in place?

Terrence O'Malley, MD, Medical Director for Partners HealthCare

[Laughter] Not a lot of the panelists are jumping in on that one, huh? This is Terry O'Malley. I think that really, from my mind, that's the crux of the issue. The LTPAC folks are working awfully hard to provide excellent care, and they're working hard to improve their processes internally, but what they—and they've sort of built into their business case the fact that their care is terribly inefficient. The keystroke errors that were alluded to, recopying the transcription, the need to go back and find essential clinical elements like the immunization status of a patient—that might take half an hour of a nurse's time to chase down at the acute hospital, where it could be instantly available, were that included in the transition data set.

But all of these inefficiencies are sort of baked into their financial model, their business model right now. I think unless that business model changes and really puts—not only puts more of a pressure on adding these efficiencies, but also gives the LTPAC site the ability to make a margin on improving those efficiencies so they can reinvest it in their process. It can't just be a one way street—"We're going to pay you less to do more"—there's got to be an option, an ability of the LTPAC sites to actually do better care, do more efficient care and actually make more of a margin doing it. I think that's going to be the trick. I can point it out, but I don't have a solution for it.

Shelly Spiro - Pharmacy e-Health Information Technology Collaborative - Director

This is Shelly Spiro. If I can, since Paul, you did address the previous panel in this—one of the things we're finding, at least on the pharmacy side, especially because the physicians who are servicing the patients who are already meaningful users, they're receiving incentives for meeting the meaningful use objectives are obliged to do the e-prescribing function.

So that can be a potential driving factor in adoption in the LTPAC setting. Because those physicians are already in the loop and are adopting EHRs, we can use e-prescribing as a process are advantages to the pharmacy, especially if we can solve the solution to controlled substances, because it's an extremely manual process for the pharmacy. So there are incentives on the e-prescribing side that can help with voluntary adoption.

Terrence O'Malley, MD, Medical Director for Partners HealthCare

This is Terry O'Malley, just to comment on that. That works fine for physicians who are part of meaningful use certification as part of their hospital or ambulatory care practice. Unfortunately, physicians who practice primarily in post-acute care settings are not—their work in the post-acute care settings does not contribute towards their ability to meet meaningful use attestation. It's an omission—it's a terrible omission.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So Terry, could you speak a little bit more to how that mismatch is happening? So the physicians on the ambulatory side are using, or might be using meaningful use certified systems, but when they're providing care in the nursing centers, even though they're billing as outpatient services, that that's somehow separate. So, can you talk about how that comes to be?

Terrence O'Malley, MD, Medical Director for Partners HealthCare

Well, part of it becomes, so the e-prescribing done through your certified EHR is—now, your meaningful use is very easy, it's built into your workflow. When you get into a long term or post-acute care facility, you are, the physician is not e-prescribing in the same sense. They're not directly contacting the retail pharmacy or the mail order with a prescription. We are writing an order that then gets given to a pharmacy intermediary.

Very few facilities have e-prescribing capability that's certified and meets meaningful use criteria. So any patient that I see in the nursing home doesn't—and write a prescription for—I'm essentially undercutting my meaningful use attestation if those patients are counted in my queue of patients. Most physicians get an exemption and just say, "A certain percentage of my work is not with a meaningful use certified EHR, over which I have no control." I think that's probably where most of the issues come from.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

And some of those issues are also workflow, right, so you're saying that e-prescribing, as done in the nursing center, is different, and that's, there's the coordination function that's happening with the nursing staff in the facility as well as with the institutional pharmacy. Is that the hub of the difference from, say, outside ambulatory prescribing or hospital prescribing?

Terrence O'Malley, MD, Medical Director for Partners HealthCare

Yes, sir. So the prescription that the physician—so, we really don't have the tools to e-prescribe in the same way. We can, some places have electronic order entry just in the sense of a step towards e-prescribing, but the orders, the different process for getting the order to the pharmacy vendor, since there's one pharmacy vendor that provides services to the entire facility. It's that link that is often not done on a certified platform.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Paul Egerman has a question.

Paul Egerman – Businessman/Software Entrepreneur

Yes. Thank you very much. I actually wanted to follow up on Paul Tang's question about the business model. My question for this panel is, why hasn't the CCHIT certification process for LTPAC, why hasn't that had an impact? Is it because there's no incentive or business reason to adopt that certification process?

Lauri Harris, RN, Avalon Healthcare, Inc.

This is Lauri Harris, and I just wanted to point out that we actually do use a CCHIT certified EHR, one of the few that are in our industry that is CCHIT certified. I think part of the issue that we find in our business is that there is such a big difference between the components of the EHR in the LTPAC post-acute environment as opposed to the acute care environment and/or ambulatory care setting. The differences in just the makeup of the EHR alone, we have many physicians and practitioners who are very trepidatious about trying to learn another type of process that is totally different than what they see in other environments.

Paul Egerman – Businessman/Software Entrepreneur

That's helpful, but since you use the CCHIT certification, how would you expect ONC certification to be different or better than what CCHIT is already doing?

Lauri Harris, RN, Avalon Healthcare, Inc.

I think the commonality between the programs of certification amongst care settings would be helpful, and that's what I anticipate the ONC certifications to be able to do is to pull together in circumstances that make sense, like requirements across care settings that allow for more integration in the care environment.

Paul Egerman – Businessman/Software Entrepreneur

Okay. That's helpful; thank you.

Terrence O'Malley, MD, Medical Director for Partners HealthCare

This is Terry. I want to jump in on the question about CCHIT, because there's also a timing and consistency issue that Lauri alluded to. The CCHIT criteria for a long term care, and they also have criteria for behavioral health, were developed prior to the ONC HITECH programs coming into being. And so we're set, if you will, at a time with slightly different standards and slightly different expectations, and so those have not been revised since the ONC program has been in place, and I know that some vendors have talked about the mismatch between those two sets of criteria as a problem, and Lauri alluded to that as well, looking to coordinate across the programs.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr. On that issue is that trust is a very important part and I think in the security and privacy thing of trusting information, of having some type of criteria will be important. I wanted to comment on Paul's point about the business model and what Terry said and all that. I think it's great that CMS is on the call and on the panel, because I think harmonization between CMS's criteria for us in home care and hospice care and skilled nursing facilities is important and perhaps the business model could be that they relieve some of the administrative things that we keep getting piled on us to do and Lauri and Laura talked about the nurse's time of documenting things would be helpful to us in the business model to enable us to be able to make a reasonable return on our investment of providing the highest care and also Terry alluded to, we keep getting cut in our reimbursement.

So I think CMS has to harmonize a little bit with us on this, especially in quality measures, because we keep getting more sets of quality measures, and I think that'll help us out in the business model.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, John. Jennie has a question, and I just want to let everyone know that we're getting close to the end of the time for this panel, so after Jennie, we'll go to Paul Tang and then we'll wrap things up. Thanks, Jennie.

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging & Long-Term Care Policy

Thank you so much. Thank you, panelists, for your very good presentation. I very much enjoyed it.

My question is, is if you could comment on whether there is clinical data that is needed and used in the long term post-acute care setting that should be referenced in EHR certification criteria that would support transitions in shared care and quality of care in these settings.

Terrence O'Malley, MD, Medical Director for Partners HealthCare

This is Terry O'Malley and Jennie, I will answer that. I think the data set that just went through HL7 balloting, the 2013 consolidated CDA update is a great place to start for essential clinical information. This data set was largely derived by asking the receiver at every post-acute care and acute care site for that matter, so we could think of what they needed to safely take care of a patient that they got from any other site. It's, I think, a very good start. It's not the final product, but if one were to adopt that as the standard and say, at a minimum, you need to be able to exchange the following set of Legos, that would be a wonderful place to start and we could build on it and make it better.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

If there aren't any other comments, we'll go to Paul Tang.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks, Michelle. Just trying to drill down a little bit more, let's say, what John Derr said about the value, both the contribution of quality but also the efficiency, let's say, of documentation. Actually, somebody mentioned that most of the documentation was done by nonprofessionals in the nursing home environment. The value is clear. We've had CCHIT certification before meaningful use. I'm not sure how much that stimulated the market. If we were to have certification requirements, would that cause people to make that extra investment—especially, as you point out, that reimbursement is getting constrained? What would it take? Is it only certification, or are there other things needed for people to decide to make

that investment in the LTPAC arena on these systems, which we all know are fairly extensive?

Lauri Harris, RN, Avalon Healthcare, Inc.

I think, in Avalon's case, we have decided to make the investment simply so that we can continue to look for innovative ways to provide information to our partners as we create strategic partnerships throughout health care, whether it be in the acute care world or as we also do care transitions with home health and hospice. It's important to be able to offer them efficiencies and kind of looking for a way to distinguish ourselves as partners in a very competitive marketplace.

Terrence O'Malley, MD, Medical Director for Partners HealthCare

Yeah, this is Terry. I think that's going to be part of the driver is those facilities that recognize the business advantage of adopting it, and then there are going to be some who actually get supported by their more well healed acute care partners who are getting the meaningful use incentives. I think it's going to be a large swath of post-acute care that has neither the resources nor the compelling business case at the moment to adopt this. I think for that group and probably for the others, there really has to be another source of revenue that will partially, at least, offset the cost of adopting the ability to exchange this information electronically.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Okay, this is John Derr again. I'll speak for my work with Golden Living and doing and spending a lot of money on the infrastructure. The reason was—and sort of backing up what Lauri said—was that we figured that we would have a better preferred vendor care provider capability if we did a standardization and had a good EHR and transitions of care, so there was a financial business model that we could say for the hospitals and the doctor's offices that we had this and were helping them to make meaningful use and therefore could be a preferred provider.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, John, and with that, we're going to have to move onto our next channel. So, for panel three, we have Lisa Harvey McPherson from Eastern Maine Homecare; Steve Chies—and please let me know later if I pronounced the name wrong—from Benedictine Health System; Scott Ranson from Brookdale Living; and Terry Leonard from Life Care Centers of America.

With that, we'll get started with Lisa Harvey.

Lisa Harvey McPherson, Eastern Maine Homecare

Oh, good morning. I apologize; I had my phone on mute. Can you hear me okay?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

We can hear you. Go for it, Lisa.

Lisa Harvey McPherson, Eastern Maine Homecare

Okay. Good morning, everyone, I'm Lisa Harvey McPherson. I am the Vice President for the continuum of care with Eastern Maine Healthcare Systems, and in that role I served as CEO for Eastern Maine Homecare.

As I talk about Eastern Maine Homecare, it's important to understand Eastern Maine Healthcare Systems, a comprehensive health care delivery system, serving two-thirds of Maine's geography, central to northern Maine, up to the Canadian border. We are honored to have been one of the national Beacon Communities. That was our Bangor Beacon Community project. We are one of the pioneer ACOs, and we also participate with the CMMI patient centered medical home demonstration project.

For Eastern Maine Homecare, we began utilizing technology over 15 years ago, implementing a strong, web based telehealth program and it's essential for us to leverage technology to serve our rural geography. For example, Aroostook County alone, our home care nurses cover 6000 square miles with 2 locations in the drop site. Using technology to effectively manage care and improve the quality of care was our driving factor, and what we know from our telehealth program, when we have patients on tele-home care, we significantly reduce ED visits and hospital readmission rates, which certainly aligns nicely with the hospital incentives.

Under the Bangor Beacon Community, we leverage growth in our telehealth program and we also were able to purchase an electronic health record system so that we would have one home care and hospice electronic health record across our footprint, and we have built the technology to interface our electronic health record with our tertiary medical center, Eastern Maine Medical Center, and from there, we've built the infrastructure, so home care and hospice plans of care go out into Maine's Rio, which is our HealthInfoNet—it's Maine's health information exchange. We've also built the infrastructure for our nursing homes to have information on Maine's health information exchange.

What we know today, because of the advancement of the Beacon Community and building out HealthInfoNet, health information exchange are integral to how we deliver care at our patient centered medical homes. We've embedded care coordinators, how we deliver care for home care and hospice and long term care, and also how we have been very successful with our pioneer ACO demonstration project.

If you think about the experience of care when patient's present to the emergency room, as a quick example, and the ED docs can go into the health information exchange, know that the patient is a patient of Eastern Maine Homecare and have access to our full plan of care. That has been very beneficial in how we are supporting patients to successfully transition out of the ED and back into the home care environment.

As part of the CMMI Patient-Centered Medical Home Demonstration Project, we've also created the community care team program, which is premised on the Camden Coalition work in Camden, New Jersey, and we're leveraging technology to provide innovative approaches in how we care for the most difficult and challenging patient population. So, through HealthInfoNet, we now have real time notification when a community care team patient presents in the emergency room when the patient registers, that information triggers into HealthInfoNet and that triggers an e-mail alert to our community care team, and we then deploy the team to the emergency room to work with the ED and transition that patient back to their Patient-Centered Medical Home environment. In the first year of the project, we reduced emergency room utilization by 64 percent with the Community Care team and technology, and we reduced hospital readmission rates by 74 percent, so we're very proud of the work that we're doing, supported by our technology.

And with that, I think I've met my time.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Lisa. Steve, are you ready?

Steve Chies – Benedictine Health System

I'm on; can you hear me?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

We can hear you; go ahead.

Steve Chies – Benedictine Health System

Great. Good morning, everybody, and thanks for the opportunity to present to this workgroup. Some of the thoughts we have in the five factor framework were establishing a new certification program for LTPAC providers. BHS supports most any effort to advance LTAC providers into the mainstream of health information technology, as we're well aware, as several panelists have mentioned, a lot of our LTPAC colleagues are woefully behind in adopting HIT into their operations. As we're also aware, LTPAC has not always been considered as an important part of the health care delivery system; thus, decisions were made not to include LTPAC providers in some of the funding and grant opportunities that were out there. We think those decisions were counterproductive in promoting collaboration within the full health care sector and specifically improving health care patient outcomes and reducing costs in our sector.

A little background on the Benedictine Health System—we're a faith based, Catholic organization, caring for about 6000 seniors on a day to day basis in the upper Midwest and about 70 business units in 6 states. Benedictine Health Systems has been on a journey to improve our health care quality outcomes over the last 20 years and we've worked very closely with the MDI Achieve software vendor with their MatrixCare product and developing and using that software system to enhance our operations. We have viewed health care technology as a key strategic initiative. It is a major tactic in our strategic planning going forward. We've allocated a little under 2 percent of our expenses to fund this category.

BHS has been a participant in a number of grants surrounding health information technology; most recently, as a part of a successful effort to electronically transfer the CCD document from an acute care provider using the Epic software directly into our MatrixCare software. This is as the result of an e-Health grant that we were able to participate in with a number of providers. This project was primarily driven by an acute care partner in the Allina Health System that wanted to have a better methodology of transmitting information back and forth, and as we know from the research, the ability to clearly transmit information back and forth between providers is one of the challenges of making sure that things are not lost and the best outcome for the patient is achieved. This CCD project is the first step in what we think is a longer journey into interoperability of health information, but we also think it's an important step. We expect to roll this out into our operations in the first quarter of 2014.

To address the workgroup's main question, which is essentially, "Would we support a voluntary certification of ONC at this time?" We probably would support a voluntary certification program with a few caveats, and let me go through those. Given the state of the HIT adoption in the LTPAC sector, voluntary certification does create vision and expectations about ONC and CMS's envisioning in HIT. LTAC providers need to understand the direction, need to assess the business purpose which the prior panel talked about a little bit in the questions; I'd be happy to answer it from our standpoint. However, this is going to take many years to complete and we need to get started sooner rather than later.

LTPAC providers are working to create new relationships and alliances with acute care providers, because those entities are searching for partners and ways of meeting the meaningful use requirements that they're seeing on their end. The pioneer ACOs are just getting started and there are a number of experimental and pilot programs out there and pilot schemes to pay providers differently that will demand an enhanced HIT process. Government pay sources, both Medicare and Medicaid, have yet to fully recognize the strategic value of investing in HIT for their internal purposes or for even their provider groups. As 80 percent of LTPAC payments are coming from those two sources, providers are highly dependent on Medicare and the state Medicaid agencies to support those efforts.

BHS, in our journey going forward, is expecting our software vendor to adopt voluntary certification and other certifications out there that will allow us to better use our information and better able to transmit this information interoperably to other providers, including acute care providers. One of the visions we have going forward is to create an enterprise wide record that will cut across all of the sectors of our delivery system, both from the post-acute payer all the way into independent living so that we can manage these individuals better.

That concludes my formal remarks. I'd just like to thank the panel for their efforts to work with LTPAC providers in getting into the mainstream of the health care delivery system. Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Steve. Scott, are you available?

Scott Ranson – Brookdale Living

Yes, I'm here. My name is Scott Ranson. I'm the Chief Information Officer for Brookdale Senior Living with 13 years of LTPAC industry experience. Brookdale is one of the largest providers of long term care in the United States with 660 communities in 36 states. My comments today will encompass both my view as Brookdale CIO and combined views of the CIOC Consortium and the Nurses' Executive Council as represented in the recently released industry white paper entitled, "Electronic Health Care Record: Solutions LTPAC Providers Need Today," which I submit to this group for your reference.

To give you a feel for the breadth and scope of the CIOC and the NEC, which are represented by most of the largest providers in the United States, we represent 46 companies in over 6000 locations serving more than 585,000 senior Americans every day. A full description of the CIOC and the NEC can be found in the white paper. My point here is, the opinion in the white paper represents a very large percentage of the post-acute long term care.

I'm only going to point out a few of the points in the executive summary, but I do encourage everybody to read the paper. EHR and EMR systems are critical enablers of the quality process and innovation demands of the current health care spectrum; the ability for health care workers to deliver excellent patient outcomes and maximize quality of life for users in LTPAC settings depends greatly upon these systems. The LTPAC requirements for EHR and EMR are distinctive, robust, full featured systems, not EHR light. That may work in the short term, but long term, we need to have systems built specifically for this industry.

I'm going to concentrate now on the certification. I believe that certification is essential for the Long Term PAC industry. If anybody can take anything from today's speech, I would say we talked a lot about the physical care of the patients that we serve today, but I would also attest that we owe the folks that we take care of the same responsibility in taking care of their digital life and their financial well-being. Data can be stolen from many areas and LTPAC software providers today are very, very small and are learning to provide safe, secure, feature rich, scalable systems. There are a few acute software vendors that are entering the post-acute care market that are trying to figure out what post-acute care means and the features and functions are very different than the acute care space.

Most LTPAC providers have very small IT departments and do not have the time or skill to evaluate software at the level needed to ensure safe company and patient data. Most recently, I'd like to give a very quick example. Brookdale adopted a software package about two years ago and if my IT department did not evaluate that software—and this was a piece of software used by many of the providers today—I would've implemented a piece of software that, on a daily basis, would have been a HIPAA data breach violation. My internal security team pointed out many features and functionalities that needed to be corrected in this piece of software before we could implement it. I pose to you today that many of the long term care providers' IT departments don't have the capabilities to question these software providers' functionality.

The space is even becoming more compliant or more complicated with software as a service providers, and in some cases, the software, as the service providers cannot provide SoftOne, which is Service Organizational Controls or SOC 2 reports. We, as Brookdale, have had to ask for these reports to be produced, and they have not even known what the definition is, let alone how to accomplish it. Brookdale has had to subsidize some of these certifications just to make sure that our software systems are compliant with HIPAA and the regulations that we need to comply with as a public company.

Certification of software for a long term care company should include but not limited to the following categories: Secure regulatory compliance, interoperability which many of you have talked about today, third party device integration, validation—and no one has mentioned this, but validation of trusted sender data quality. We need to know the sender of the data is who they say they are and the data that they are transferring in fact is accurate for determining quality of care; core base functionality by care setting with coding standards.

The economics of certification I think should be borne by the software providers. If they are truly serious about providing quality software for providing quality care, they should want to certify their applications for the companies that choose to use them. Certification of the quality of data should also be the responsibility of the provider. We, as Brookdale, should ensure that our employees are trained well enough to put quality data in that we're going to exchange.

Overarching reasons for LT involvement in the ONC policy and the certification process: Seniors today spend days and weeks in the acute care space. They spend years with us; in some cases, 15 years, and as someone else pointed out earlier today, the amount of money spent in long term care sometimes can dwarf the amount that was spent in acute care. Customer's homes in long term care represent a large number of hospital readmissions. We've already heard that today. Long term care is in the best position to help reduce this quickly. In order to reduce this, we need scalable, reliable systems designed for long term care and for interoperability.

Given the sake of time, that's the end of my comments and I'd be glad to take any questions and I appreciate the opportunity to present our position.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Scott. Terry?

Terry Leonard – Life Care Centers of America

Yes, thank you. My name is Terry Leonard. To put my comments in context, I'll give you the Life Care perspective. We operate over 220 skilled nursing facilities across 28 states. We have 26 home health agencies and a new national physician's practice which dedicates physicians to individual skilled nursing facilities. We have about 80 physicians on board at this time.

A few years ago, we abandoned our approach to acquire commercial best of breed clinical application software. We now internally develop our core clinical applications. In fact, our EMR was certified for stage one meaningful use just this year. For health IT development, we concentrate mostly on nursing, therapy, and physician software. I would say that currently one of our biggest challenges is integrating the employed physicians into our processes and software in the nursing homes. Although this is difficult, we're already being rewarded with lower hospital readmission rates and also more effective care transitions. We believe the physician program is significantly improving our quality of care.

Next, I'd like to comment on health information exchange. We're involved to varying degrees in numerous state HIEs. Those include Massachusetts, Tennessee, Colorado, Washington, and Indiana. It appears to me that there's a tremendous variation of approaches to this nationally. I think those states which were awarded challenge grants may have a good head start, and Massachusetts is a great example of that. The driving use case for me is that of improving safe transitions of care. In fact, we have moved corporate leadership positions with responsibility for safe transition programs. I believe HIE efforts would concentrate on the technology without compelling use cases or struggling today.

We're already getting considerable pressure from referring hospitals to exchange health information with them. Unfortunately, these are usually requests for ad hoc connections and not through a formal HIE. Many times they want our facility associates to log directly into a hospital discharge system to input and receive information. That may be great for the hospital, but then we're left with manual input of the information into our own systems. I would like to see the standards and efforts around formal HIEs to be pushed much harder. Without this push, it's hard to see successful interoperability any time soon.

Even though we don't have interoperability just yet, we're moving in the right direction. Due to our recent certification process, we've built in some key capabilities. We can now import lab results, submit immunization registries with HL7, submit syndromic surveillance files with HL7, provide clinical summaries in the form of a CCD, and also receive CCD/CCR format from external sources. I'd like to give credit to the current certification process for the incentive to develop these capabilities, which will move us at least towards some level of interoperability—that being the certification for the meaningful use that I'm referring to.

Now I have some final comments on certifications. I know there are some voluntary certifications for LTPAC specific software; those have been mentioned today, but we did not elect to pursue them for our internally developed software. I'll have to say that we pursued the EMR modular certification for our physician software in response to incentives. Those dollars will help us offset some of our development costs. More important, we can avoid the upcoming penalties with regard to Medicare reimbursement. The only reason we can take this advantage is that we are employing physicians. Typical nursing homes don't have that ability. I really think those nursing homes without employed physicians should be eligible for some type of related incentives as well.

Although necessary, the actual software certification process isn't being resolved. By testing to the meaningful use measures, I expect our physicians will see much more efficiencies and consistency going forward. Having achieved the meaningful use should also help our standing with referring hospitals. Having just completed our certification process, we're well aware of some of the challenges. There are many requirements which don't really make sense in our particular settings, but we had to write the code just to check the box. One example is a provision for growth charts. With our elderly demographic, we really don't need growth charts.

With that being said, I don't want to seem too negative. I fully support the standards and certifications as the best way to move forward in alignment with the overall health care continuum. Even though our costs are not fully covered, I expect more value to be achieved later on as we achieve interoperability. I hope my comments are helpful and I thank you very much.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you very much, Terry. I don't currently see any questions from workgroup members.

Scott Ranson – Brookdale Living

Well, that means we did a good job, then.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

[Laughter] You covered everything. Paul Egerman has a question.

Paul Egerman – Businessman/Software Entrepreneur

Yes; another great panel. I had a couple of questions for Terry Leonard. First you said that you certified stage one and you've done meaningful use of stage one. Are you trying to do stage two?

Terry Leonard – Life Care Centers of America

We're evaluating that right now. We're working on the 24 ...stage one. Being in long term care, we're a little bit lagging in that, and of course it's a new process for us employing physicians, but we do have that on our strategy.

Paul Egerman – Businessman/Software Entrepreneur

And so—well, you say you're evaluating it. Does that mean you're trying to decide whether or not you're going to do stage two, or you're just evaluating what you intend to do, or you're just evaluating what's required to get it done?

Terry Leonard – Life Care Centers of America

It's a little of both. Honestly, from a business perspective, the biggest long term issue is the Medicare penalties that will be imposed, and it's not really clear exactly what those will be long term, so clearly we're looking at that. It's an expensive proposition to, each time we have to certify our software and make the changes, and as I pointed out, some of the changes we make are not really applicable in our particular setting of care, but we have to do it anyway. We have to certify our product as if it would be for sale on the outside, and that's not the case with us.

Paul Eggerman – Businessman/Software Entrepreneur

That's helpful. You make a good comment about, I like the way you describe it with growth charts where you have to sometimes write software just to check the box as opposed to writing software that will be usable in your setting. One of the questions that I have is this whole LTPAC arena or area, where there's such a great diversity of settings, of hospice care and rehabilitation services, home health care, nursing facilities—is it possible to write a single LTPAC certification process that will work across all those settings without causing people to do what you described, you know, write some software just to check the box?

Terry Leonard – Life Care Centers of America

I think it's possible, but it is going to be difficult. I mean, we're already sort of living in that, because we brought physicians into the mix and changed the process, but that's really part of why we decided to build our own software in the first place, to be flexible for any kind of setting or any kind of evolution of the processes that we do that we can meet the challenges.

Unfortunately, as Scott pointed out, for most of the LTPAC community, they can't afford that. They don't have the resources I have to develop software, and so you raise a very good point. I guess that's why I'm here today; I'd like to be a voice in that. It is a concern, but we still need to pursue it.

Scott Ranson – Brookdale Living

I would agree with Terry. This is Scott Ranson—I agree with Terry's comment. It may be difficult to do, but it is necessary in this industry because of the multiple care settings that we have. It just, it should be mandatory.

Paul Eggerman – Businessman/Software Entrepreneur

But should you need multiple certifications for each setting, or one for hospice care, one for home health? Would that help? I've been, I'm still worried about this sort of, I guess, one size fits all in this industry.

Scott Ranson – Brookdale Living

Well, we need to stay away from specific feature—it's difficult to say that you should have in a certification specific feature functionality. I think there should be an overarching standard around security and privacy and all those fun things I mentioned, but maybe there are substandards, right, based on the care setting or for specific functionality, so it may be difficult to do, but there are certain things that will apply across all care settings, and then there may be certain things that apply just to specific care settings, but I mean, that's the world we live in, so it should be done.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr. When we set up the CCHIT, we did divide the different care settings, but as Scott and Terry said, we did have security which was sort of the minimum standards, but we did have a separate group for each of the different care settings, because they are different; especially with MDS and OASIS.

I have a question for Steve Chies. Steve, when your pilot with Epic and all that, did anything come up about standards in your working with on that case with MDI Achieve and Epic? Would standards help, or anything you want to say about that?

Steve Chies – Benedictine Health System

Well, I think the issue, John, is having an agreed upon format, and if you want to call that standard, then I would tell you yes. I mean, we use the CCD as the model, and that was a good starting point. I don't think it's the end point. I've been in the facilities talking with the nursing staff about it and they said, "This is a great first step; now what about X, Y, and Z?"

The goal was to create the bridge to create the agreement to be able to transmit the information and then we're going to build on it going forward.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Paul Tang has a question.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks, and thanks to the panelists; very interesting. I think Terry Leonard really had a nice perspective in the sense of, even though you're not getting paid—well, one, you have a self-developed system that's just one system, not one for facility and one for docs, right?

Terry Leonard – Life Care Centers of America

Yes, yes. I mean, we're covering all disciplines. It's not one database, but yes, one system.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, and then you—so that's internally developed because that was the best way to fulfill your needs, and you decided to do MU certification one, I think you said, because it helped you put in some functions that were useful to your physician. I know growth charts are not; in fact, they should be some kind of exception, but at any rate—and that you made a comment that MU certification helps your standing with potentially referring either physicians or hospitals. I thought that was a very interesting additional insight in terms of what does this do for you—you obviously made the investment.

You did refer to other folks who may not have that same capability, how does this help them? I think Scott addressed that. Steve opened an invitation to say, "Hey, you can talk more about business case," and I would be interested in that. But I think what I heard from Terry is, even though the business case may not be completely clear to everybody, without a certification program, even those to want to invest in HIT, whether it's homegrown or otherwise, have difficulty getting the value out of it without some kind of standards, without certification in the sense. Did I hear that correctly?

Terry Leonard – Life Care Centers of America

Yes, you did, and as far as the standing with the hospitals, what we're seeing is a big change in acuity of patients being sent to us. We're forging kind of relationships with the hospitals knowing we have dedicated physicians that are sending us higher acuity patients, so that's really a competitive advantage for us.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Right, okay, and then can I take—Steve, I also wanted to offer to expand on the business case.

Steve Chies – Benedictine Health System

Well, certainly I think people have shared with the expectations of the hospital, that's certainly a business case, and being able to be a preferred provider, and even in to enter into ACL payment arrangements that allow us to adopt some risks really are evolving around that.

I give you a couple of other areas. One is that the ability to standardize your internal operations using software and technology is a basic quality improvement process. Now, we've been working extensively in the quality improvement process in our jurisdiction. In fact, earlier this year, we received a fourth level of essentially the Malcolm Baldrige Award on the state level and we use our HIT system to help us standardize processes and protocols at that point, but more importantly, when you talk to long term care providers, and if you take a look at the Medicare RUG system or you take a look at states that use case mixed systems, the ability to compile data on basically ADLs and the other functions in those facilities helps to give a more accurate picture of the patient and the reimbursement follows more accurate position of the patient. I can tell you that we have done case studies within our organization that being able to more accurately predict the ADLs in a 24 hour, 7 day a week basis increases the revenue stream into those buildings, and we've gone into buildings that have never used it with their MDS and they have substantially increased revenues just by more accurately portraying the patient in the MDS system.

We find it, as I said, a strong strategic initiative for us, in our quality, in our reimbursement, in regulatory compliance, and then with our partnerships in the alliances that we see being developed going forward.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Stan Huff has a question.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Yeah. In the discussion, it seems to me that there are two parts to things we're talking about that we don't always distinguish. One is sort of standard setting and certification of the system and then meeting meaningful use measures and I wanted to ask the panel, what would be your feeling, I guess, of relative value of the standard setting and certification capabilities that move us towards interoperability versus, if you will, requirements and other responsibilities relative to quote meaningful use in terms of setting common measures that we're sharing and that activity. Do you have a feeling for that, whether the greatest value is in standard setting and normalization towards interoperability, or sharing of measures and quality information around sort of the actually meaningful use requirements?

Terry Leonard – Life Care Centers of America

I'll speak to that. This is Terry. Really, I'd say it's equally important, really. I think even an expansion of the meaningful use of the workflow of it, we're seeing better coordination of care within our facilities among our caregivers. Historically, it's been a little bit of a separation between nursing and therapy and the physicians, and by doing this, we're seeing it pulled together.

To me, it's another push for having consistency of the meaningful use across the LTPAC setting. We're having some difficulty, for example, with workflow whereby, is it the nurse that enters vitals in her system or is it the physician that enters it and how they get to it? It's as much of a workflow issue as anything else, but I think the driving to meaningful use and understanding these workflows is a big part of it. Where it gets to interoperability is really huge as well. There were comments earlier about e-prescription. That in itself is difficult for us as well in the long term setting as was reported earlier. Most of us have institutional pharmacies where we do the prescription inside the building, but now that I have physicians, we have to also be able to do prescriptions out—sorry, I'm getting an echo.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yes—if you aren't the one speaking, please mute your line.

Terry Leonard – Life Care Centers of America

The point to that is, we had to build two prescription systems; one for e-prescription outside the meaningful use, and the other one to be integrated with our internal pharmacy. So once we get to interoperability, some of those barriers, I hope, will fall away for us.

Steve Chies – Benedictine Health System

Yeah, this is Steve Chies. The response I would give you is that whether it's meaningful use or it's standards or voluntary certification, whatever pathway gets us closer to be able to be in the mainstream of where the health care delivery system is going to be in the future is where LTPAC providers need to be. Right now we're getting a substantial amount of pressure from acute care providers to be partners in participating in the health care delivery system, and they want to be able to exchange data and as one of the other panelists mentioned, they're more than willing to give you read only access to their software, but that doesn't meet our needs going forward as partners and providers. So whatever pathway gets us closer to the mainstream is what we want to support and pursue.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Yeah, I guess part of the—this is Stan Huff again—part of the motivation for my question is that the standards criteria seem to be more universal in the sense of creating the ability to exchange either structured data or CCDAs and standardization of terminology, whereas the meaningful use criteria seem to be much more environment specific. I mean, we already mentioned the growth charts and other things, but maybe it's just, maybe what's needed is a way of, a more flexible way of saying which meaningful criteria and measures should apply in a given environment and get away from sort of the current one size fits all in terms of the meaningful use criteria. I'd appreciate people's perspectives on that.

Or not. *[Laughter]*

Terry Leonard – Life Care Centers of America

I don't know that I have much more to add. I think you're definitely getting to one of the problems. The one size fits all issue is a problem, and I think this is something we need to resolve and I guess, again, I think it's part of why this forum is coming about. The certification of LTPAC systems in light of the meaningful use, if we—now's the time to level the playing field as much as we can, but as Scott pointed out earlier, there's always going to be exceptions. I mean, I have a totally separate system for my home health division, and we've got to get around that someday. We've got to have consolidated systems.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Absolutely.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Well, if there aren't any other comments from the group, I don't see any more additional workgroup questions, so perhaps we can move on to our next panel.

So, for panel four, we have John Damgaard, Doc DeVore, Karen Utterback, and Cheryl Hertel. So John, if you are ready, we'll get started. As a reminder to all panelists, you have five minutes, and go ahead, John.

John Damgaard – MDI Achieve

Can you hear me?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

We can hear you.

John Damgaard – MDI Achieve

Very good, very good. Good morning. My name is John Damgaard, and I'd like to begin by thanking Dr. Tang and the members of the workgroup for this important work and also for the efforts to embrace the LTPAC community in the proceedings.

My day job is Chief Executive Officer of MDI Achieve, provider of the MatrixCare electronic health record, which is an ONC 2014 certified platform and one of the most widely used platforms across the LTPAC spectrum. I also currently serve as the IT Committee Chair for the National Association for the Support of Long Term Care. Prior to my work in LTPAC as a core system vendor, I was a vendor of clinically intense ancillary systems that needed to integrate tightly with the acute care EHRs before and during the initial meaningful use push. So I've seen the promises and pitfalls of interoperability in health care from a variety of angles and a variety of settings and across a wide swath of vendors.

First of all, quickly, many LTPAC providers are to be commended for their forward thinking with respect to the use of IT in their businesses. They have not adopted EHRs in complementary technology because they were told to or incented to or paid to, these are very savvy business people who foresaw their futures tied to the need to deliver higher quality care at a lower overall cost, and they rightly recognized these technologies as levers to do so. The aging population, the customer of my customers, is stressing our health care system. We will continue to deal with more chronic conditions across longer episodes in multiple care settings requiring interaction from a diverse care team across many physical sites. Effective transitions of care within this environment hold the key to higher quality, safer care with overall lower costs.

Supporting effective transitions of care should be the focus of our IT certification efforts. A certification process that actively verifies platform compliance to designated HIE protocols and standards including the consolidated CDA/CCD formats would provide assurance that the building blocks to supporting effective care transitions are in place in a vendor's solution. I use the phrase "actively verifies" with purpose. From my experience, simply asking a vendor to attest to the relevant standard is not enough. They need to prove it, and at least to simulate an environment. Vendors—present company excluded, of course—are notorious for developing proprietary extensions to interoperability standards and attempts to gain and protect market share. In a sense, it's natural behavior. I fought those wars as HIT evolved in acute care, and I believe that we can avoid that non value added business in LTPAC. Our providers are under enough margin pressure; we don't need to increase their burdens by passing through the costs of our own bad behavior.

I also believe that the establishment of a national level certification process focused on care transitions can head off the otherwise inevitable growth in state level standards. As a vendor who has to maintain a large EHR system to deal with 50 similar but different and ever changing sets of regulations around reimbursement and other matters, I would very much like to see us avoid that. It's unnecessary complexity, and it just drives up costs and dilutes innovation.

On the note of innovation, I believe our certification efforts should be limited to the focus on transitions of care. We're talking today because we have effective telecommunications standards that describe how phone systems connect. We don't try to say that your phone system has to have a certain voice mail feature. Likewise, inside the bounds of an EHR platform, vendors should be free to innovate and determine which features warrant investment and provide them with a competitive advantage. The market will determine who wins and loses. Overreaching on certification requirements just drives up costs—growth charts for old people, for example—in an already margin challenged environment.

So, in conclusion, I believe there is tremendous value for all stakeholders in a certification process focused on active verification of support for effective care transitions and secondly, in a margin challenged environment where technology adoption is not subsidized or incented directly, we should avoid certification requirements that overreach. To do so will needlessly drive up costs for all, despite important innovations on the part of the vendors. I would again like to thank the workgroup for your efforts—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, John.

John Damgaard – MDI Achieve

- and for inviting me.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

John, thank you.

John Damgaard – MDI Achieve

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

We'll now move on to Doc.

Doc DeVore – Answers on Demand

Thank you, and thank you for inviting me today to testify. I want to say that the comments before have very much predicted what I might say. As I and other members, some of whom are on today's panel, begin the work on the HL7 workgroup which later became the Balanced and Long Term Care EHR functional profile, we really hope that we can have a day like this where we can have the occasion to share our thoughts about how health information technology can improve the care of millions of residents that we're honored to serve.

As we talked about, by and large, this important community has been overlooked and yet the providers in LTPAC are the true experts caring for those with chronic and complex health conditions. I learned a long time ago when working for a small chain of skilled nursing facilities how hard it is to coordinate the complex care needs of individuals who move around the spectrum to multiple care settings seen by multiple conditions often not affiliated with each other and then they have long, serious spells of these conditions. The result is that they experience many transitions of care, and those transitions become the dangerous opportunity that we have to either exacerbate their condition or to make it a seamless and harmless part of the process of aging.

At AOD Software, we're fortunate to serve and partner with very forward thinking providers and understand that there's real benefit to health IT, and they are increasing their use of this technology as we've heard from some of the providers earlier. They're doing that to improve outcomes and become more efficient and the market continues to face reduced reimbursement from their peers. They know that they can become more efficient and increase their ability to respond more quickly to the health conditions of the residents which leads to better care and also to significantly reducing the need for transitions and avoiding unnecessary hospitalizations.

This is why AOD supports a voluntary certification program that will set standards for the exchange of that information. It's like AOD set out almost three years ago to become the first LTPAC HIT vendor to achieve such certification, first with an ONC 2011 edition modular, and later with the comprehensive CCHIT LTPAC 2011 certification. We took that risk even though we knew that our provider partners were not going to receive any incentive for using that product, nor would they likely pay any more money for it. The hundreds of hours and thousands of dollars, however, have proven to be beneficial in several ways, and I'm going to mention just a couple.

The first thing we learned after certification was that our provider partners were excited about the opportunity it gave them to tell their story to their partners, the hospitals, HIE organizations, the potential for ACO partnerships, and they want to know their settings to know that they were ready to become fully interoperable partners in the longitudinal care using interoperable technology. Sadly, the second thing we learned was that the other settings were not ready for us. In part this was—and still is, to some part, because the acute care partners were focused on meeting meaningful use measures that didn't include or apply to LTPAC.

The major reason is that the standards were and still are today not standard enough. As critical as the exchange of the central clinical information is to transitions and coordination of care, we continue to experience severe challenges. There's a lack of true agreement of what should be in the CCD, what data should be shared by whom and when and how that data should be transported to the other side, a lack of a true national health information network infrastructure results in multiple point to point communication channels which often use different technical standards for exchange. The result is duplication of efforts without realizing the benefits that HIE could bring to all care settings, not just LTPAC.

Indeed, we find that sharing the Continuity of Care document is a phase two or phase three, often, of these projects where lab results and just the exchange of demographics and using some of the older ADT standards have been the primary interest, and a lot of hand wringing about what to do with the CCD—and yet it could be the most valuable tool to avoid the manual process that is commonplace and inefficient.

A voluntary certification using the 2014 edition ONC based EHR definition would go far in assuring providers that their EHR meets certain minimum standards for function, content, and interoperability, allowing LTPAC providers to confidently work with their acute and ambulatory partners to build a network of sharing that is in synch with federal requirements for all settings. In an effort to achieve these results, we urge ONC and others to be mindful that there are also real costs to implementing technology—certification that's built to meet the base EHR definition would not be overly burdensome.

We caution that it takes time to do it right. It's not possible to take a system built for hospitals or physician practice and simply tweak it for LTPAC. We serve a unique population that cannot be addressed in an episodic approach. S&I framework has done some good work so far in furthering the suggestions that many of us made at last year's LTPAC roundtable. We need to exchange meaningful data in a way that promotes a knowledgeable collaboration on a long term plan of care for our residents. If not, we risk continuing the ambulance problem, you know what I mean? That's the problem where the pressure ulcer must have happened in the ambulance, because we sure didn't see it in the documentation that came from the transferring entity.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Doc; I apologize.

Doc DeVore – Answers on Demand

No; I was done.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, perfect. *[Laughter]* Karen? If you're ready, please go ahead.

Karen Utterback – McKesson

Good morning. My name is Karen Utterback. I am currently the Vice President of Strategy and Marketing for McKesson Technology Solutions Extended Care Solutions Group. We represent over 15,000 technology employees, and 230 of those are dedicated specifically to the long term post-acute care market space.

I appreciate the opportunity to testify and share McKesson's perspective about how the LTPAC certification program could impact us. I'm a Registered Nurse and have more than 32 years' experience in the hospital, LTPAC, and health IT space. This experience has provided me a unique perspective on the need for the providers, customer, and appreciation of how health IT software development, adoption, and use supports the operational efficiency of organizations and influences the delivery of quality care in the long term post-acute care setting. McKesson is a member of the National Association of Home Care and Hospice, and I serve currently as the chair of their ... section, which is focused on technology. In that role, I work closely with Richard Brennan and other vendor members of that community.

Our long term post-acute care settings provide a rich opportunity to support improved care transitions, continuity of care, and care coordination, and early interventions for those receiving post-acute care services, and those dealing with chronic conditions by using the data and information that is commonly contained in their EMR systems today. Adoption rates of EMR technology, particularly among home health and hospice providers, are among the highest in health care, and the adoption of the EHR products positioned for long term post-acute care providers to be ready and able to exchange the valuable information that they've collected.

Many vendors, including McKesson, similar to what you've heard from the prior two presenters, have made significant investments in the form of participation in industry and ONC based work groups and in product development. McKesson specifically has participated in many of the S&I workgroups and additionally has created an interoperability solution which is standards based and was introduced to the market over a year ago, and again, similar to those previous presenters, what we found is, the other settings, hospitals and physicians specifically, were just not ready to be able to participate in a meaningful way for the exchange of those CCDs and CDAs.

We also see the benefit from a workflow and a business perspective of the opportunity for significant reductions in data entry and in limiting the number of errors that occur by using the information that is contained in the EMR systems and ultimately to reduce the burden of the use of phone and fax transmissions that are often difficult to manage organizationally and to retain the documentation of the fact that they occurred. Based on this experience, we are opposed to the concepts of certification, not for what they will bring, but specifically for imposing those prior to adoption of meaningful use stage three. We see that as the point when their communities can come together and actually begin to share and have confidence that there will be, if you will, someone on the other side of the door when they knock with the information.

Again, we believe that the industry is well positioned to start this participation; however, the timing is dependent on adoption rates on the hospital and physician sides. A specific example would be that transitions in care requirement for meaningful use two is at 10 percent. Well, work systems within post-acute care settings can't build workflow and operational efficiency around an expectation of 10 percent. It means they're again retaining and maintaining duplicative processes and workflow systems in order to benefit or participate in the electronic exchange. We believe that by requiring or even imposing the voluntary burden will introduce new costs and little benefit without some confidence in the higher adoption rates.

Another real concern for us in the vendor community is, as was mentioned, the variability in state requirements. Minnesota is an excellent example of that, one that has passed state legislation to require the use by post-acute care providers of a certified EHR in 2015 without clarity on what that certification requirement will actually entail and putting us, as vendors, at risk for creating potentially 50 different versions of our solution.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Karen. We'll now need to move on to Cheryl.

Cheryl Hertel – Cerner Corporation

Thank you. Hi, good morning. This is—my name is Cheryl Hertel, I'm a Registered Nurse and Vice President within Cerner's Population Health Organization. Thank you very much for extending the invite to allow me to speak on behalf of Cerner's stance on the topic.

I have the responsibility for multiple business units supporting community care including home and hospice care, long term and assisted living, as well as network and interoperability. Cerner's been in the EHR business, as you know, for more than 34 years and over the years we've participated in numerous certification programs, both voluntary as well as involuntary, both inside the United States as well as outside the United States. We currently support more than 3000 post-acute care organizations across the United States with core EHR technology as well as support for interoperability between systems. The LTPAC care venue is an area that demands support for quality transitions of care and care coordination across a multitude of providers. The EHR becomes the foundation and enabler for a shared source of truth.

The most important aspect of participation in a certification program—in particular, a voluntary certification program from Cerner's perspective, is the value that the certification program will bring to the patient as well as support for the care providers providing the care to that patient in that care venue. Our experience and success with certain programs that we've participate in over the years have been directly related to the clarity and definition of guidelines and functional requirements, and how these requirements align to the anticipated or expected improvement in patient outcomes.

When assessing the value of a certification program, whether mandatory or voluntary, we tend to look at it from a couple of angles. From a federal or state program level, if the certification is driven from a federal program, we view the follow as the following: That certification typically enables ascertainment of requirements in support of public policy objectives that may otherwise go underserved. Meaningful use is a great example. It helps drive capabilities in the health care IT significant support high priority policy objectives that might not get achieved otherwise. They bring clarity and focus on enabling interoperability and what is defined to be a significant priority for whatever program requirements are reflected in certification, so such things as electronic prescribing, sharing of diagnostic lab results, sharing a visit summary, sharing of record summaries with consumers with the providers as well, just to name a few.

These programs tend to serve to push the industry forward on requirements suppliers and their provider clients might not take up as a priority left to their own sense of market demand and road mapping. For a supplier, it can be costly to adjust development planning; however, the value proposition in expected improved clinical outcomes become a driver that, when mandatory, is uniform across the market segment, which really helps to support that care venue and the clinical outcomes of the patient. They can also work to set priority for standards, developers to address gaps and implementation challenge within existing standards and to provide a source of prioritization for our development.

When looking at purely voluntary participation certification in our experience in this space. If left purely as a voluntary certification, it serves more as a market differentiator or, if you will, a Good Housekeeping seal. Participation in a voluntary certification program can be a leading indicator for development of criteria that reflect the capabilities that the industry experts believe significant to a given care venue for the use of EHRs such as in the LTPAC space. If the certification program is truly reflective of capabilities that are necessary to support the care process in a particular venue, participation can ensure that the EHR will indeed support the care venue with minimal additional changes to software once deployed. It can also help provide a roadmap for new entry into a market segment that a supplier may not have been in before.

With that said, we recognize that the LTPAC market segment is indeed in need of standards based certification to ensure quality support for care coordination across the continuum of care. We're supportive of such certification programs if the requirements truly support the management of transitions of care and enable a higher level of care coordination in the LTPAC care venues, higher quality outcomes for the patient. However, we question the adoption rate of the voluntary program versus a federally required program and question if the industry will achieve the significant level of care coordination process improvement if not tied to mandatory programs driven from a federal level that have incentives to support the adoption levels in the LTPAC care venues.

Thanks for providing me the opportunity to speak.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Cheryl—and John Derr has the first question.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Yeah, this is John Derr. I wanted to address this a little bit to Doc. I know your software is used in a lot of community care retirement centers where people go in for independent care, assisted living, skilled nursing. I was wondering, you've sort of had an informal certification between these different settings; if you could comment on whether there is some type of quality improvement or better care in that you have this integration between multiple different care provider settings.

Doc DeVore – Answers on Demand

Well, thanks, John, for the question. I think one of the things that we found with working with the CCHIT certification is that the type integration across the spectrum was beneficial, but we also learned a lot by studying those requirements because we needed to be able to share data from one care setting 'til the other, even within our own system, and certainly had some understanding about what would be required to share that data across to other provider settings external to an organization.

So I think—and that's what I was alluding to, I think, in terms of our plant base jumping on this, because they saw the value of that interoperability as they worked with their partners. I don't know if I'm addressing your question or not, John. Help me out if I'm not.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Well, one of the things—this is John Derr again. One of the things we've talked about is, if we did have some voluntary certification, we would improve the care between the hospital and the LTPAC. We would improve quality of care—

Doc DeVore – Answers on Demand

Right, right. Okay, yeah. Sure. I think you're right, John. I think because many of our clients are like some of the ones earlier in the panel, do care across multiple settings, having some standards based approach to how to share data, that has value all the way through the spectrum, okay? Unless that provider better cares for that person as they—I guess, to borrow a place, age in place. John, I've heard you so many times talk about how we, as we get older, bop around that spectrum of care, and that's the reality in this space, and so you need to have some standards based way to describe the current condition in a way that's meaningful to the next setting.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thanks.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Paul Egerman has a question.

Paul Egerman – Businessman/Software Entrepreneur

Yes. First I want to say thank you to all four of the vendors for the important presentation. If I heard it right, there was a fair consistency. At least there of you seem to be saying certification should be focused on or perhaps entirely into all of those transitions of care; if I got that wrong, please correct me. The question I have is, what we're going to do is talk about standards and transitions of care and perhaps the CCD document. Is certification necessarily the right vehicle, or are there alternatives to create standardization? For example, if there existed a test kit—I don't know what else to call it—from the government from this that would test whether or not you are compliant with transmitting or receiving information, would that be a useful alternative to a one size fits all certification process, especially if the test kit were something that a purchaser or a user could use to validate their software?

John Damgaard – MDI Achieve

Paul, this is John Damgaard. I think I directly addressed or at least, or came close to directly addressing that idea in my comments that what I think we need to do is focus on the effective transitions of care and that process to certify or, as you mentioned, maybe there's an alternate way to do that—needs to involve n actively verifying the compliance, and what better way to do that than in a simulated environment or, as you put it, a test kit.

I think that's a great idea. I don't know if that is a separate vehicle or maybe a mechanism in the certification process to streamline or to sort of make it very objective. I think it's a tremendous idea and I'd be happy to donate you such a system.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and John, I did hear that in your comment about verifying which—I mean, almost by definition ... the government does with certification has to be objective. It has to be simply a test that exists that is published, the criteria is well known and you either pass it or you don't. There should be nothing subjective about it, and certainly nothing about attestation, considering the fact that there is no ability to audit and no penalties for false statements, so it simply has to be a test.

The question I'm trying to ask is, is there something—is certification necessarily the right vehicle to use here, especially when we possibly have this concept of a problem of one size fits all, that maybe there's a test kit for transitions of care and there's a test kit for e-prescribing and there's test kits for a series of other things, that that could have the advantage of vendors that only have to produce what they needed to produce, but might have another advantage that you—would have another advantage that certification would not carry with it an implication of approval or quality of the software, which it doesn't necessarily validate?

Doc DeVore – Answers on Demand

Well, this is Doc DeVore, and I'd like to echo some of what John said. I like the concept that you have, because I've long said that the problem with the current standards is that they are flexible. That's also the beauty of those standards, and so it does give you the ability to customize in a setting, but it becomes then the challenge of how do you write the software that works across the multiple settings or with exchanging data to others who work in a slightly different setting or with slightly different needs?

So I do like the concept that you have, because I think it addresses the real need of the provider community to know whether a system meets the specific needs that they have for exchange of data. It's almost, I almost hear you suggesting something like a UL seal of approval for a specific kind of task. I know that the RJ45 jack always is an RJ45 jack, and so I think you're saying the same kind of thing about the exchange of data. I like the concept, and I think it has some value, but I think it has to be approached in almost a certification way. There has to be the UL group and if that's ONC who says, "Okay, we have a kit that says this is a standard"—so there's got to be that certifying authority, if you will, that providers can look to and say, "Okay, I used the kit, I tested my EHR, and it does work."

Cheryl Hertel – Cerner Corporation

This is Cheryl. One of the things that—I listened in on Brian Yeaman's piece earlier this morning and, through that ONC grant challenge, I'm wondering whether we can't use some of the successes that we've already seen in the industry as a basis for such a type of a seal of approval or a certification process. We've got successes out there that are occurring that are really focused on dealing with a significant issue that we have today in transitions of care, and I think that's why we all reference transitions, because it is top of mind.

It's probably one of the highest priorities, not to say it's the only one, but if we can go tackle that and get a standard or a recommendation out there to provide good guidelines to move quickly through that piece, we can then go focus on other things relative to LTPAC that are also just as important, but it's that care coordination and that transition of care that was mentioned earlier where there's only 10 percent uptake in the industry today. We've got a significant issue and we've got some real success stories out there through some of the challenges that have been put out there and we should be taking that, learning, and then looking at that as something that could provide a foundation.

Karen Utterback – McKesson

So this is Karen Utterback, and I would agree with those comments and also with the question. I do believe there is a better way to approach this and the concept of using existing standards and then acknowledging or adopting the plan of care that was put forth to the HL7 balloting committee a few months ago. I believe that the existing standards combined with that transition in care plan, if you will, is what we need in those transitions and would bring a significant difference to the action care of the patient without the burden of the full certification program.

Paul Egerman – Businessman/Software Entrepreneur

So Karen, if I understood your comment correctly, in what you said before, you are opposed to certification, but you're saying this approach is sort of like a middle ground that you would not be opposed to; is that your outlook?

Karen Utterback – McKesson

Right. The reason we're opposed to certification is not in principle, it's in practicality, because of adoption rates and because we're in the business of creating a product that has to have a market. Right now, what we're find is, because of the immaturity of the meaningful use standards and the adoption rates, it is immature, and we believe that a narrower focus, one that would use existing standards and complement that with a plan of care would not only relieve much of that burden, not create a full certification program, not create an unlevel playing field by doing a voluntary certification program and getting the competitive forces that will surround that, but yet focusing on what can actually bring value to the patient as opposed to acute care providers into the physicians and hospitals as they move through meaningful use into meaningful use stage two in a stronger way.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Jennie Harvell has a question.

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging & Long-Term Care Policy

Thank you, and thank you to this panel. I appreciate that you've come. Earlier this morning, we heard from long term post-acute care providers and clinicians that work in these settings about their need for EHRs and their support for EHR certification criteria that would support e-prescribing, clinical decision support, public health reporting including lab results and immunization data, and also EHRs that would support transitions of care and also shared care across different clinical disciplines. We also heard earlier today about the importance of EHRs having sufficient privacy and security infrastructure to support the data and then just now I think various members of this panel discussed the lack of readiness by physicians and hospitals to be able to receive information from long term post-acute care providers.

So, in view of all of that, I was wondering if the panelists would be able to address the following two questions. Should there be EHR certification criteria that supports the functionality that the earlier panelists, the clinicians and providers, described as needed in long term post-acute care? That's the first question, and the second question is, if there is such certification criteria for EHRs in long term post-acute care, what do the panelists think the impact of the use of such certified products would be for the long term post-acute care provider and also for the hospital and physician provider? Thank you.

Doc DeVore – Answers on Demand

Jennie, this is Doc, and I think others on the panel will probably agree—like John had said earlier, I think we have to be careful about being overreaching in the certification process. While I don't disagree with many of the earlier comments, I think all of them were appropriate when we talk about syndromic surveillance and we talk about the ability to monitor medications and catch keystroke errors and all of those kinds of things—if we build that or bake that into an overarching certification program that has to be complete, then I'm concerned that the development effort will be too expensive to begin with and will result in less likely adoption by, first by the software providers themselves and then later the adoption upward.

I'm sure the other panelists, you can add some things. I don't disagree with a lot of the things I've heard today, but I think there is real need—I think a common theme I'm hearing all the way through, the ability to exchange data that is meaningful to the other setting is one of the most important things that can be done right away to immediately improve the care of our senior folks.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Doc, this is John. I think those are great comments. Just to add to that, I'm perhaps putting myself a little bit out in the open here, but the reality is, and I've discussed this with representatives from our CIOC Nurse Executive Council and a variety of different individuals on this call that there is an element of champagne taste, beer budget here. The relative investment for a full scale electronic health record for a major acute care health system has a couple of extra zeroes in it relative to what even the largest providers in LTPAC are able to invest.

The fully integrated, rules based clinical decision support technologies, we're all introducing these, but we're introducing them as the economics allow, and I say we all are; I assume other vendors are as well. We certainly are. But there is a challenge. There is an economic reality here that is very different. There are not billion dollar deployments of EHR systems on the LTPAC side of the fence. It's a very different economic model and a very different price point, and to impose that menu of functional items on all systems, I would echo Doc's comments—I think it's not going to have the intended effect. It's going to have a whole series of unintended consequences.

I happen to be one of the best funded of the group, and I look at the problem and run from it. It's a real challenge. There is an economic reality here that has not been reconciled. We don't have stimulus money, we don't have other sources of subsidization here, and it's a real problem that needs to be recognized.

Cheryl Hertel – Cerner Corporation

This is Cheryl Hertel with Cerner Corporation. I think the question around the need for things such as decision support reporting, medication management within the long term post-acute space—I mean, there's no doubt whether those pieces are needed. It's at a little bit different level of sophistication compared to what we see in our hospital setting. However, the same need is there to be able to provide those systems that provide the overall care of that individual patient and ensure that the systems are bringing the data necessary to provide the best quality care for those individuals.

I wonder if this doesn't break it into two pieces where there is one that is focused on the use of the EHR in the LTPAC space versus the care coordination transitions of care piece that seems to be kind of so imminent. There's definitely a layer of extension of that core foundational EHR out into the long term care space as a means to create that continuity and force of truth and have that reflective capability when that patient moves from that care center into the hospital and then back again, because today that's a bit that's missing in the inconsistency and the flow.

And so the use of the EHR in that setting is definitely a different care venue and emphasis on the care providers that are there caring for those individuals in that setting. In our experience so far to date, we definitely go about those deployments in a very different manner. It's much more lightweight. However, there are some core principles around decision supports that still apply whether that individual is in a long term care setting versus in the hospital, those conditions still require that decision support to be there, so there's probably a layer of lowest common denominator pieces that apply broadly, whether you're in the hospital or outside of the hospital, and then others that are probably less demanding in the long term care center versus what you would see in the hospital.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Paul Tang has a question.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks. Actually, I just wanted to clarify something that was said by Karen and then referred to by Cheryl, which is the 10 percent transfer of care documents. The 10 percent—so first of all, these percents are just low, medium, high. The reason it's 10 percent is because it's the introduction of that requirement. The other piece is that from the provider point of view, so if you consider all the different kinds of providers, including those in rural settings, they may not be able to have a lot of LTPAC providers that they can communicate with who can receive—well, it's not LTPAC, I mean, it's all other entities, electronic transmission. So that's why it's a low percent.

We know from all of our past experience that once you turn on functionality, you don't go to say, "Well, I got my 10 percent; I'm outta here." The people blow past these thresholds in the major league. They're all above 90 percent, virtually. So we can't have a kick in the ... where the vendors are not going to do anything until all the providers—that doesn't make any sense. I think, I just wanted to clear up that misconception that when they're available receivers of electronic transmission, then I would expect that that would happen all the time, but not in every part of the country can you have anything close to 100 percent. That explains the low percent, but I would urge the vendors to think that—well, they have, no one can do more than zero percent if the vendors don't support it, so we really need your buy in to developing the systems and being able to receive and to transmit.

Karen Utterback – McKesson

This is Karen. We fully support and understand that, and that's why I chose to tie the comment to meaningful use stage three and maybe that's not the best way to try to articulate what we've seen, but as we developed products and customers were excited about having that sort of opportunity to participate and share the information, what they found—and it's common for, particularly in the home health and hospice environment, for an individual provider to deal with a large number of physicians and hospitals. And they're quite strapped for operating funds in order to be able to put in place the most optimal workflow for their staff. So as they begin to explore, "Well, if I put the product in place and I can actually start to send a CCDA from my home care application back out to my physicians and my hospital, how many of them can actually receive the data and actually, even more importantly, send information back to me?" That ability was very low, so I understand as we move into meaningful use two that that gets better, but there's still a long period of time from now until—essentially, 'til we have the adoption of meaningful use three that you do have this chicken and egg, and you do have the building of a market rather than a clear market, which makes it a challenge for the vendor community to make the investment and to be able to have some confidence that they'll see a return on that investment.

Doc DeVore – Answers on Demand

I can—this is Doc—to echo what Karen's saying, I think the announcement last Friday that stage two is being proposed to be extended and stage three to be delayed is exactly what we're talking about. There is so much being done right now in that space that it's difficult to get them to engage the LTPAC community in ways that are easy to do.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. John Derr has a question.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

I wanted to comment, pertaining to really heavy certification and putting a heavy burden on the vendor's neck, one of the reasons we formed this group in that and we have encouraged to volunteer was, the other alternative was that maybe we were evicted criteria, because it just makes logical sense that we'd have transitions of care across the spectrum. So one of the reasons—that's why we need the help of everyone on the panel and on the group to do the minimum and maybe this test kit thing is kind of a neat idea.

One of the questions I wanted to ask, mostly I think it's to John and to Doc, especially John who handles a lot of independent owners who are looking out there, these 3000 to 4000 nursing homes and small home care agencies that don't know what to do and are sort of sitting and waiting back to be told to do something. If we did have this volunteer criteria which was sufficient with an agency like ONC that says that, would this help these people that I'm afraid might go bankrupt, go out of business because they don't know how to do the transition of care? Would this help them to be part of the care spectrum?

John Damgaard – MDI Achieve

Well, I think—this is John. I think it would guide them, John, in selecting technology, but again, to tie it back to the previous comments, the hospital referral sources, if we're speaking to the skilled nursing crowd, who require their preferred nursing home providers to use a system that has been certified to be able to do electronic transitions really is the hammer.

The fact that we are able to offer a series of systems for them to choose from that all have the seal of approval, shall we say, certainly eliminates the issues to a large extent that the gentleman brought up before where he found that he had a system which was full of sort of basic holes, the seal of approval—which I assume embodies the privacy and security piece as well, would certainly say, "Hey, here's the end number of choices, and these folks focus on big, these folks"—you know, whatever it is. We all have our competitive strategies and our differentiations in the market, but I think the fact that we all just had seals wouldn't necessarily help the independents or the smaller chains spur them to action, John. It's really going to be upstream with their trading partners who are going to sort of dictate—in my opinion.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Larry Wolf has a question.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes ... you can ask it, though. So we've had our discussion about some of the forms this might take, and I wanted to clarify that what I'm hearing is that there's, as regard to the various kinds of information exchange, that each of them really has its own set of rules today. So, for example, e-prescribing is a different beast from care summary exchange and that any test certification criteria really needs to reflect that diversity and allow for independently testing and certifying each of those. The value in testing is that not only is there value in having a test ... but there's also value in having something stronger than self-attestation that says I used the test ... in order to actually create that floor and create consistency.

So I guess I'm hearing a piece around what's required to make the exchange work, the comments around if there's really going to be an interoperable standard that you can plug and play, it needs to be more constrained rather than less constrained. That seems to be really important.

As to the other things, we're hearing a range of things about value of things like clinical decision support and how does that get implemented in a way that's appropriate in the settings. We are going to, we're actually looking to change workflow and change behavior, but it should actually have a net benefit, not just a net cost.

I guess I'm hearing two related but sort of not necessarily related conversations about, that both affect what goes in certification criteria. Any comments from the panelists, as we're just about to run out of time?

John Damgaard – MDI Achieve

I think you nailed it, Larry. This is John. I think there are two separate but related topics, the areas of interoperability, care transitions being primary—e-prescribing is a great one. There are multiple vendors in long term care. They each have their own unique connection requirements and certification requirements; it's a zoo, unnecessarily. So I think that and then, with respect to clinical decision support, there are core principles and good practices that can be imposed or used as guidelines in all systems, but I don't know that that is a certification issue. I see it as a competitive advantage issue, plain and simple. Now, I'm not a clinician, but I see it as a competitive advantage issue.

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And just to quickly echo what—I'm sorry; I'll stop.

Karen Utterback – McKesson

This is Karen. I was just going to say I would agree with that comment fully.

Doc DeVore – Answers on Demand

Larry, Doc here. I would say that it's important to delineate the two and I think, as many of the earlier speakers today have said, if there is not some way to incent, either through payment mechanisms or inspection mechanisms, the adoption of those systems, just having the certification by itself is not going to help.

Cheryl Hertel – Cerner Corporation

This is Cheryl. I'll just add one more comment. I think the certification around some of those components really relative to improved quality outcomes to the patient—that is really the significance around the need for certification on those elements, and then I absolutely agree on the incentive side if it's tied to an incentive program that actually provides value back to the organization itself is undergoing the cost on implementing those components that makes it easier for them to digest and bring those on, which—and then for us, from a supplier side, it supports our investment because we know we're going to get higher level of adoption in the industry.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, and with that, I just want to thank everybody on the vendor panel. We appreciate your feedback. We're now going to switch to the fifth panel, which is the regulatory quality improvement panel. We have Karen Tritz on the line, Stella or Stacy Mandl, Crystal Kallem, and Darrell Shreve.

Karen, if you are ready, please go ahead.

Karen Tritz – Centers for Medicare and Medicaid Services

I am; can you hear me?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

We can hear you.

Karen Tritz – Centers for Medicare and Medicaid Services

Great. Members of the workgroup, thank you very much for the opportunity to discuss our work at the survey and certification group within the Centers for Medicare and Medicaid. I'm the director of the Division of Nursing Homes in the Survey and Certification Group in the Center for Clinical Standards and Quality. I began this role in November and joined the Division of Nursing Homes this past February and have been with the Survey and Certification Group since 2006.

As background, the survey and certification group does survey a variety of long term care providers, home health and hospice, but I'll limit my comments to the nursing home survey and certification process. The Division of Nursing Homes is charged with the oversight and quality assurance of nursing facilities through the survey and certification process. CMS contracts with state governments to perform health inspections and fire safety inspections of Medicare or Medicaid certified nursing homes, and to investigate complaints about nursing home care. The health inspection team consists of trained inspectors, including at least one Registered Nurse. These inspections take place on average about once a year, but may be done more often if the nursing home is performing poorly or if there is a complaint. Approximately 15,800 on site comprehensive standards surveys are conducted each year in addition to about 50,000 on site complaint investigations that focus on a particular area of the complaint.

During the inspection process, surveyors will take with nursing home residents and staff, observe the care and services being provided, and review the medical record. Generally it is a team of about three to four surveyors on site for four days. Surveyors do encounter electronic medical records in nursing facilities with increasing frequency. I would like to share a recent anecdote that underscores the importance of the EMR functionality settings and the surveyor's activities in identifying important quality and safety issues.

In August, the nursing facility indicated that they would discontinue a specific EMR they had implemented five months earlier as part of a plan of correction in response to a survey. In this case, among other problems an individual was given an excess dosage of Coumadin because the electronic medical administration record kept all Coumadin orders, even when the dosage was changed. The result was that the nursing staff didn't then trust the system and reverted back to reliance on the paper documentation and contacted the medical director frequently to verify the orders. Our division is following up with this particular case, but it does raise the broader questions of, to what extent can an EMR certification process include disclosure and follow up of any software problems identified, whether it be through the certification program, CMS, or both.

I'd also like to discuss a few of the issues and opportunities that surveyors may encounter in trying to access the electronic medical records, which can be characterized into three broad categories. The first is the access and navigation. When the surveyors enter a nursing home, can they get an access code for read only access, or does the surveyor need staff assistance for access? How quickly can that take place? The CMS surveys are entire unannounced. If access to an EMR even takes a day, it can delay the entire survey process. Anecdotally, we have heard surveyors sometimes start a survey on Sunday so that access would be available on Monday when they want to do the majority of their survey or start the survey.

The second issue is portability and how does the physical access actually work. If the surveyors have to use computers that are located solely in a conference room, this takes time away from observation of residents and observation of the facility, which is the core part of the survey process. If the surveyors are given a laptop or if the surveyors can access the EMR system from their own laptop, it would assist in the efficiency of the survey process. And just as background, in about half of the states, we use what is called a quality indicator survey or QIS. This is a software product to assist surveyors in conducting the federal survey. The QIS survey currently interfaces with CMS national data sets to get broad resident and facility characteristics. It would be interesting to consider if an EMR certification program could also include certain interoperability with this QIS software.

The final issue I would like to highlight for the panel is the issue of comprehensiveness and documentation, meaning the ability of the EMR system to sort of navigate the timelines and trends across components of the record. For example, if a surveyor found in a record that a resident had fallen, part of the surveyor's role is to determine what the facility's activities were and intervention was, if any, and what has happened since. So it would be imperative for the surveyors to be able to look across modules of the EMR to understand the timeline of how the different care components fit together, so what medications were ordered before, immediately prior to the fall? What kinds of therapies does the resident have, and what's documented in the care plan in terms of follow up interventions afterwards, and it's necessary to sort of put those side by side.

If there was a—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Karen. I'm sorry; your time is up.

Karen Tritz – Centers for Medicare and Medicaid Services

Okay, I'm sorry. I was just about finished. I appreciate it and would be happy to take any questions folks have.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Karen. We're going to move on to Stella or Stacy Mandl.

Stacy Mandl – Centers for Medicare and Medicaid Services

Hi, thank you. This is Stacy Mandl. I'm a technical advisor in the division of chronic and post-acute care. I'm also joined by Debbie Hattery, who is the Director of the Information Systems Group. CMS would like to thank the HIT Policy Committee Certification and Adoption Workgroup for the invitation to participate in this important discussion of a long term post-acute care certification program and its impact on patient assessments. CMS supports the expansion of meaningful use and interoperability of EHRs that would facilitate the electronic transfer of patient health information across all settings, including the LTPAC settings.

We are aware that interoperability rests with the use of assessment data uniformity. Currently CMS collects uniform data by setting and post-acute care. Early work related to cross setting assessment data uniformity began with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, also called BIPA, requiring the secretary to submit a report to Congress on the development of standard instruments for the assessment of the health and functional status of Medicare patients who received hospital rehabilitation, SNF, home health therapy or other specified services. Further, the Deficit Reduction Act of 2005, or the DRA, directed CMS to develop methods for consistently measuring Medicare beneficiaries' health status across acute and post-acute care in the PAC settings. The DRA also established a post-acute care payment reform demonstration, also called PAC-PRD, to use the standardized data and development recommendations for refining current PACs payment methodologies.

The DRA calls for standardized assessment items to be used in the acute and post-acute settings, including those participating in the PAC-PRD.

The care tool was developed as part of the National Post-Acute Care Payment Reform Demonstration, and this was mandated by Congress under the Deficit Reduction Act. In addition, the care tool was evaluated for interoperability. The subsequent care tool data set comprised from uniform data elements was designed to standardize the assessments of patient medical, functional, cognitive, and social support status across acute and post-acute settings and was designed to standardize the items used in each of these existing assessment tools while posing a minimal administrative burden to providers. Its development was a multi-pronged effort that elicited extensive input from numerous stakeholders, experts, clinical groups, and information technology experts.

The PAC-PRD and work related to the care tool allowed CMS to identify multiple potential concepts surrounding the application of uniform assessment based data elements including the ability to use and re-use uniform information and the electronic transferability and interoperability of such common information. We look forward to working with our colleagues at ONC and the Health IT Policy Committee to further explore implementation of EHRs in the PAC setting and service of accelerating improvement and now comes from Medicare beneficiaries. I appreciate the opportunity to provide some information and background related to the current state of our standardized assessments that are required by CMS for submission to us and background related to the data uniformity which we believe are important to facilitate data transferability.

Data uniformity is clearly imperative as a starting place for data interoperability often puts information at the atomic level. In post-acute care, we use standardized assessments that are standardized for the providers by the provider type using standardized data elements. Those would be the minimum data set for SNFs and NFs, inpatient rehab facility Patient Assessment Instrument, the IRF PAI for IRF, and patient rehab facilities, the Outcome and Assessment Information Set or OASIS for home health, and the Long Term Care Hospital Continuity Assessment Record and Evaluation Data Set or the LTCH CARE data set, and a Hospice Item Set, which is actually based on chart extracted data will be implemented in 2014.

This data is submitted to CMS electronically by providers via the _____ system using our submission specifications which we post on our CMS website by provider type setting. The MDS was required. Just a little background—the MDS was required. Its requirements date back to 1983. In 1987, the Omnibus Budget Reconciliation Act required the creation of a national minimum set of standards of care and rights for people living in certified nursing facilities. OASIS was required also by regulation in 1999. It established the mandatory use collection in coding and transmission of OASIS data for all Medicare and Medicaid patients receiving home health skilled services.

The IRF PAI was established by the Balanced Budget Act of 1997. It also further established that the IRF PPS will utilize information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. The LTCH CARE Data Set—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Sorry, Stacy; your time is up. Thank you very much.

Stacy Mandl – Centers for Medicare and Medicaid Services

Okay, sure.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

We'll open it up for questions. Crystal?

Crystal Kallem – Lantana Group

Yes, thank you. My name is Crystal Kallem, and I am Director of Business Analysis and Policy at Lantana Consulting Group. I also serve as co-chair of the HL7 Clinical Quality Information Workgroup. On behalf of Lantana Consulting Group, thank you for the opportunity to provide input today.

Lantana currently provides services and software for standards based health information exchange. We built our expertise through more than a decade of involvement in standards development and deployment. Lantana's work focuses largely around interoperability specifications, although we see interoperability specifications not so much in and of themselves, but a means to an end; that end being a more data driven health care system. Lantana's mission is to transform health care through health information exchange. Our comments focus on those areas of particular relevance to our expertise with the HL7 clinical document architecture and electronic clinical quality measure reporting standards.

We suggest leveraging the meaningful use program to improve long term and post-acute care health information technology capabilities and patient centered care. This testimony suggests tactics for leveraging stage two requirements while moving towards stage three objectives. It addresses candidate HER certification and clinical quality measure requirements in the context of a vision for coordinated care based on a cohesive electronic record, and in the context of a comprehensive transition strategy.

First and foremost, LTPAC EHRs must be included as part of the broader HIT interoperability strategy to support coordination of care. LTPAC EHRs should share many capabilities with ambulatory and acute hospital EHRs. Setting specific EHRs should contain unique extensions or characteristics that align with the inherent capabilities of a base EHR. When determining the shared capabilities, patient centered care should be the focus. When considering these options, there may need to be some changes to the meaningful use definition of a base EHR.

Secondly, information required for LTPAC quality measurement should leverage clinical information recorded in the patient record. LTPAC clinical quality measures should be derived from the quality data model, a framework that encompasses data from EHRs and other sources to manage measures of health. EHRs can then process these clinical quality measures to guide the collection and reporting of LTPAC quality data. Decision support rules derived from CQMs will then prompt providers to do the right thing.

The same clinical information must be made available for transitions of care. We envision incremental incorporation of structured data in and out of LTPAC EHRs. This is a similar strategy taken under meaningful use for ambulatory and acute hospital EHRs. This supports the big data incrementally structured approach: Large volumes of primarily narrative data in CDA format can begin flowing from LTPAC EHRs, which can then be augmented by structured data as business needs dictate. This strategy meets the needs of front line clinicians involved in transitions of care while increasing availability of richer, structured data needed for quality reporting, decision support, and shared care planning.

Our fourth recommendation focuses on public/private consistency. Public and private pairs should agree on and promote consistent and efficient methods for electronic reporting of quality and health status measures across care settings. Today, provider's EHRs have to support incompatible reporting requirements for quality measure data. This places a development burden on vendors and a workflow burden on providers. Establishment of a consistent, computable representation of measures is a precondition to harmonization.

Lastly, LTPAC reporting requirements should be harmonized with clinical data required for patient care. This will require harmonization of data elements across various LTPAC reporting use cases. Incrementally, harmonized data elements should then be mapped to meaningful use standards. The outcome of this level of harmonization will reduce data collection burden for providers and enable greater data reuse.

Thank you for your time today.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Crysal. Darrell?

Darrell Shreve, Aging Services of Minnesota

Thank you. I'm Darrell Shreve, I'm with Aging Services of Minnesota. We're the state affiliate of LeadingAge. I was asked to talk about Minnesota's mandate for interoperable electronic health record systems. It was a mandate that was passed in statute in 2007 and the implementation date or the requirement for the electronic health records utilization is January 1, 2015, so it's a little over a year away. The requirement is to use an electronic health record system that is certified by ONC pursuant to various federal statutes and regulations. It's required to be interoperable so that it connects with a state certified HIE service provider and it affects nearly all health care providers in Minnesota.

I would say that, just to explain that statute a little bit further, there is no penalty, there is no enforcement mechanism and it's our view that it's more of an aspiration or a goal than it is an actual requirement. Having said that, the state has conducted two surveys of nursing homes on the adoption and utilization of electronic health records in 2008, 32 percent of the respondents had electronic health record systems. In 2011, 69 percent had EHRs installed and in use and that's with a response rate of 83 percent. I suspect if we did the survey in 2014, the 69 percent would be at least 80 percent and perhaps as high as 90 percent. It's been—and that's really basically without any Medicare incentive payments available. It's been during a period of time when nursing home rates paid by medical assistance, which also set the private pay rates in Minnesota, have been mostly frozen from year to year, and it's been with a mandate that really doesn't have any enforcement penalties, so it's been a very voluntary adoption of the electronic health records in Minnesota.

I'd be happy to take any questions.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you very much, Darrell. John Derr has a question.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Yes, I actually have two questions. One is for Crystal. I think that's very exciting what Lantana is working on, and in this harmonization of quality measures, how are you going to implement that? Are you going to give us a set of criteria? I was just wondering because we're talking about a voluntary set of criteria standards. Are you also working on that? Excuse me—that's for Crystal, and then for Stacy, can you comment more on the CARE assessment program? Is that going to eliminate the PPS, IRFs and OASIS and MDS, or is it going to be on top of those other assessments?

Stacy Mandl – Centers for Medicare and Medicaid Services

Hi. Did you have one question for Crystal and one question for Stacy? This is Stacy speaking.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Yes, Stacy was on the CA—and thanks for the pane. I think this is great, because if we don't have harmonization between the government and CMS mainly and what we're trying to do in providing better care, it won't work. I just wanted—I've heard various things about the CARE program or CARE, and actually when I was CIO at Golden Living, we had five nursing homes that were in the pilot program for CARE. That's very good, but I don't know whether it's going to replace MDS or when it's going to be implemented.

The one for Crystal is more on, how are you implementing this EQM type program with standards or certification or what—excuse me.

Stacy Mandl – Centers for Medicare and Medicaid Services

Crystal, you—this is Stacy. Are you all right if I just jump in real quick?

Crystal Kallem – Lantana Group

Sure.

Stacy Mandl – Centers for Medicare and Medicaid Services

So I didn't get to the other part of my little five minute presentation. So the CARE really helped us establish a lot of the key aspects of what I think a lot of folks are talking about, which is data uniformity at the atomic level which—my understanding, of course, is that that is critical to transferability use and reuse of information. CMS believes that data uniformity and moving towards data uniformity, not just in this setting specifically but across settings, is critical to facilitate as part of our part in transfer of information. It's also what's needed for us to develop and implement measures that can be harmonized across settings like we have done with the pressure ulcer incidence measure.

As far as CARE replacing any specific set of or specific assessment tool, CARE was a smattering of a lot of data elements from a lot of different settings. There was tremendous convergence of expertise that went into the data elements that were crafted and placed as the CARE tools testing, and I want to just also thank you for your participation in that exploratory work. Out of the data elements, a lot of data elements related to function had very high inter-rater and validity scoring, high kappa scoring and so about six quality measures have been developed related to function, and we have found that function is very central to a lot of our mission in being a national quality strategy and the CMS quality strategy.

I'm not exactly answering your question; CMS is certainly exploring movement and capability towards uniformity which really, I mean, is the use of uniform, consistent data elements in multiple settings to enable consistent quality measurement capabilities and it would certainly, I think, foster and facilitate data uniformity—transfer of data. Lantana is our named contract that supports our efforts towards standing up a CMS assessment data element library and the data governance support, so that once we are able to incrementally move towards uniformity of data elements, the integrity of those data elements are protected, so I'm going to hand it over to Crystal next, to answer the rest of the question. Thank you.

Crystal Kallem – Lantana Group

Thanks, Stacy. Here at Lantana we're working with a variety of stakeholders through HL7 processes to actually develop standards for quality measure expression and transmission formats. A lot of that work is currently being used as part of the meaningful use stage two program and we're actively working with a variety of stakeholders to support enhancement of those standards for the purposes of meaningful use stage three.

There are some differences in the existing transmission formats used in LTPAC settings, so we'll take some time and effort to help streamline those processes. Our initial focus is to try to help LTPAC providers get the data flowing first by using structured documents with minimum metadata requirements that then allow the information to get flowing to frontline clinicians and then eventually identify which of those data requirements should be structured to support various secondary uses such as quality measurement.

There also needs to be some alignment and harmonization with the quality data model for those clinical quality measures that are currently used in the LTPAC setting. Certainly the quality data model is designed for use within electronic systems, and that would certainly align with the existing meaningful use requirements. I hope that answers your question.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr again. I was just—I'm somewhat, we talked about earlier in all the testimonies of the extra work that the nurses have to do and all of the administrative responsibilities that we have in LTPAC to meet the requirements and didn't want to have, I think we have to know about what you're doing and what CMS is doing as we go down our trail to give our recommendations to the Policy Committee and I just, every once in a while I get concerned about the piling on to the people that work in our nursing homes that takes away from direct care. I just—the word harmonization is very important to us, and I think all of us working together, and I assume you're working with the MAP group at NQF that has an LTPAC segment to it to make sure that we're all in harmony. Thanks a lot.

F

I want to thank you. I do want to quickly respond to your comment. I want to thank you for your comment. We are extremely mindful of burden. It would be—it would do nobody any good to add additional data elements on top of the minimum data set that has somewhere in the range of 900 data elements, so I appreciate your comment, and yes, I did present, actually, at the MAP on Tuesday.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thank you very much.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Jennie has a question.

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging & Long-Term Care Policy

Oh, yes, I did. I have a question for Darrell. Thank you very much, actually, first to all the panelists for their participation today and their testimony. It was very useful and informative.

Darrell described your survey and adoption rates with respect to long term post-acute care providers—nursing homes, I believe—and you described it in the context of lack of any incentive or any disincentive. Even in that context, you described significant increases in adoption, which I think is very interesting and useful for this panel. This was good to hear. So I have a couple of questions about your statement. In your survey work, have you identified which vendors or products are being used by your long term post-acute care providers, and also I had a question regarding the use of certified EHRs in your state. Have you seen, or do you anticipate the use of certified EHRs that had been certified to the ONC 2014 edition.

Darrell Shreve, Aging Services of Minnesota

Those are all good questions. Let me address the vendor question initially. The 2011 survey showed that it did ask about which vendor the particular facility uses and, by far, the most popular vendors were PointClickCare and MDI Achieve. At that time, neither of them had certification from CCHIT. I don't know to what extent they or any of the others qualified under 2014 certification from ONC. There were several CCHIT certified vendors in 2011, but they were—their pick up rate was minimal, via a few facilities that had each of them. Overwhelmingly, PointClickCare and MDI Achieve were the most popular choices by quite a bit. That was—that's the situation there.

On the certification question, the state has, in its guidance that it's provided now for providers, has basically said, if you don't have a certified EHR, we'd like you to use a qualified EHR, and they spell out some of the functionalities that they would like to have in a qualified EHR. I believe that's in a document that I hope I sent around to everybody. To my mind, what Minnesota demonstrates is that this has been very much a market phenomenon and that the nursing homes in particular had their own reasons for purchasing EHRs, not particularly related to the mandate, in part—well, nursing homes are exempt from the mandate in Minnesota, actually, but they had their own reasons. Certification, the certification systems that were available during those years were significantly more expensive and so a lot of nursing homes have purchased systems at a cost of frequently \$40-50,000.

We have encouraged our members to ask about certification for at least being a qualified EHR, because we think those things demonstrate a commitment to the industry as well as the benefits of the standardization, all the other benefits that have been talked about on this call, but certification has not been a major factor, I think, in the decisions made by SNFs in Minnesota.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Larry Wolf has a question.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Sure. Actually two questions. Since Darrell was just talking about use of EHRs in Minnesota, those are really amazing adoption numbers. Do you have any sense of what functionality people are using? Did you drill into specific functionality when you were doing the surveys?

Darrell Shreve, Aging Services of Minnesota

The survey did not drill into that to any great extent. I will say that since then I think most—well, clearly the major utilization is for internal purposes. The handling of the MDS, the handling of census data, care planning, quality assurance activities, by and large the systems that are primarily used for internal operations of the SNF. There are a number of SNFs that would like to be able to transmit data, whether it's a PCD or others, but the interoperability structure in the state is not terribly well developed for communicating between hospitals and SNFs, SNFs and home health or home care, assisted living. The one part of the provider system where there is well developed interoperabilities is e-prescribing.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, because I guess my concern is, the numbers are really, really impressive, so I'm reluctant to go on—I don't really know how to compare them to the functionalities, say, in this ATHR and whether these systems, where they would wind up if they did attempt to get meaningful use certified. I know some of the vendors subsequently have gone for modular certification, so there is a trend in metric. I don't want to [Cross talk], sorry.

Darrell Shreve, Aging Services of Minnesota

I think that would be the direction that they'll go with modular, yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, so—the other piece is really sort of the dialogue between Stacy and Crystal about what CMS is doing and what Lantana is seeing in terms of use of data uniformity, because I think that that really is a great goal, and that it's actually an essential goal, as well as that we've leveraged the clinical information that's recorded in the EHRs.

But I've got a concern, and so this is a little bit looking at the specific history that Kindred has had with the new LTAC hospital reporting requirements for pressure ulcers, which has been almost universally an added burden for us of value. We have a very long-standing, very detailed wound documentation pathway ... medical record and that information is fed over to an analytics environment where we look very carefully at not just the ongoing care needed to manage somebody's risk and prevent wounds and then manage wounds that people come to us with or that develop while they're in our care. In fact, they often come to us because they have wounds that are healing very slowly.

What we found was that we needed to bring in specific reporting software for the reporting requirement and we need to add additional staff to meet the assessment criteria as defined by CMS. We're not able to reuse the information that we actually need to provide care, so while at a macro level the intention was right, in the execution, it's been highly problematic. I think that that tension is not just one that Kindred's experienced but in fact permeates all of the assessment tools in post-acute care.

The measures that are being reported make tremendous sense at a macro level, but if you actually drill into the care process, many of them require specialized assessments only being used to report out that the data that's needed to provide care needs to be both more specific in its attributes and often more granular in its elements than the assessment requires, so there's a separate step to do the reported assessments. I don't want to completely be on my own soapbox around this, but I feel like that really is a very key piece in the message as we go into looking at certification programs. Getting the details right is absolutely essential.

I wonder, since we do have panelists here, to bring it back to Stacy and Crystal, if you could talk about your sense of how the details of getting information that's part of the care process are informing the way you think the assessments are going.

Stacy Mandl – Centers for Medicare and Medicaid Services

So Crystal, do you want me to go ahead and take the lead on this?

Crystal Kallem – Lantana Group

Sure; go ahead.

Stacy Mandl – Centers for Medicare and Medicaid Services

So I want to just circle back to one comment—and I appreciate your comments, I appreciate your concerns. I'm a nurse, so I'm certainly aware of additional documentation and the burden that it drills back to. Just to clarify, CMS has not required, in the LTAC quality reporting program, the addition of any staff for submission of the assessments. I just want to make sure that that's clear.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

In order to do the assessments, we've had to hire additional staff because of specifics around when assessments need to be done and when they need to be reviewed. Meeting the letter of the law has required extra bodies to do it. It's not in the mandate, it doesn't say hire staff, but to meet the reporting requirements, it has in fact required hiring staff.

Stacy Mandl – Centers for Medicare and Medicaid Services

Okay. The measure that's created from the incidence rate of pressure ulcers, as a nurse, really does tie back to basic clinical nursing, which is assessing for basic wounds, much like you would prepare a patient for the operating room or receive a patient in the recovery room or into the performing ESI in the emergency department or receiving a stroke patient. But I appreciate your comment, and certainly what is critical is looking at natural patient care flow and identifying data elements that really are clinically relevant and identifying what you need to help guide the patient care. So I appreciate your comment, and I'm certainly welcome if you would like to submit your comment to the LTAC Quality Reporting mailbox, that would be a plan. I'm sure you folks have commented on that.

In some ways, you gain and you lose by meeting the specificity, and I'm actually glad to hear you say how important it is to have the granularity there, that big buckets are not necessarily helpful, because really, having the constraints of specificity is, in the end, really what we do clinically right. We get down into the weeds when we're caring for patients and noting their health status, so that's actually very good information for me to bring back to CMS and to keep in mind. But as a clinician, data elements that are meaningful and usable that are helpful in transferring care of information over to another setting, I know I look simply at the New Jersey required transfer of care form that's required by state law that has sort of large buckets, but that state has a very low pressure ulcer incidence rate in our data set. I just wanted to kind of highlight that.

So we know that information, however imperfect, does help drive quality if it's applied correctly; I can never remove the critical thinking piece. I'm going to tie it back over to Crystal.

Crystal Kallem – Lantana Group

Thanks, Stacy. My thoughts with regard to your question are that this is going to take some time to really evolve the processes and we'll need to look at this as an overall strategy to get us from point A to point B. I do envision that this will be an incremental approach similar to the processes that took place with regard to the hospital and ambulatory settings for meaningful use, many of the critical quality measures needed to be transformed for use within an electronic environment. So there's going to need to be some transformation required. When and how that takes place, I think, still needs to be assessed, as also some of these requirements are tied to regulatory requirements, so those are some of my initial thoughts.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Thanks.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Paul Tang quickly has a question and then we need to move on to the next panel.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, thank you. I'm picking up actually on what Larry was talking about with respect to Minnesota. Darrell, I easily was extremely impressed with the stats; I just want to understand them better so that we can understand what we can learn from you.

I think I heard you say they had to use meaningful use certified EHR or some kind of qualified EHR, which I guess is defined by the state. I thought I heard you say they had to comply with, be certified to operate with Minnesota HIE, but that may not be true.

Darrell Shreve, Aging Services of Minnesota

Technically that's what the statute says, but the certification is not tied to meaningful use, necessarily, but it is tied to ONC or CCHIT, but it's not a requirement.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, and then you mentioned some of the things that, functions they did have like being able to handle an MDS care plan, insurance, prescribing, and what you called internal operations of staff, and yet you said there's not much communication amongst entities in the state.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Darrell, this is John Derr. I'm on the Minnesota Technology Committee, and I just wanted to make sure when—it's a very active committee that's made up of the LeadingAge and AHCA, and that study is a very high number, but a lot of it was tied to MDS and that type of thing, so it's probably a little bit overstated and I was just on a call a few days ago and we're concerned we're not getting as much cooperation with the hospitals on the HIE, so I think, Paul, we have to take that 60 some percent a little bit—that it's a little high, and not say it's—

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Right. Is there a way we can get that report, maybe? That would maybe help to calibrate as well.

Darrell Shreve, Aging Services of Minnesota

I'll work with them and get it to the committee.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thank you.

Darrell Shreve, Aging Services of Minnesota

I would agree that, yeah, to have the exchange, you have to have another party on the line and that party hasn't always been there, although there's increasing interest in that because of the focus on readmissions and transitions of care, but to have the electronic exchange, you've got to have interfaces at both ends, and that does not exist widespread in Minnesota.

M

And the state is coming up with funding to help out skilled nursing and home care agencies, too, so the state's really working hard, but I think the communication—and Darrell's very active on these things as well—but it does show a state working together and then the problems have come up in that environment.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay. Thank you to everybody on that panel. We are now ready for our final panel for patients and caregivers. We have Leslie Kelly Hall, Sandy Atkins, and Joanne Lynn. A reminder to all of our panelists, you do have five minutes, and we will start with Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks, Michelle. This is Leslie Kelly Hall from Healthwise. We're a 34-year-old not-for-profit committed to helping people make better health decisions, and I have slides, so please bring those up.

Next, please. So about a year and a half ago, a group of consumers and consumer advocates put together, in the patient's voice, along with patients, some key principals that we hope will be carried forward as we consider long term post-acute care the patient as a contributing care team member, "Nothing about me without me," making sure that comparisons in quality also include the patient and that patient facing systems should not be encumbered by current EHR technology and that with every EHR technology there is a patient facing system reaction.

Next. Key themes that relate to long term post-acute care as we consider certification, "Nothing about me without me."

Next. Cc me some or all of my records in every transition as we know that a Medicare patient has an average of 14 providers and the transitions are some of the areas where the patient can contribute and learn much.

Next slide, please. Patients' preferences inform care, safety, and decisions, and should be considered in any effort.

Forward, please. Patient is a contributing care team member. Their data, the information they produce is valuable in care.

Next slide. The patient is a credible source of information in all care settings.

Next. The data the patient generates is material for care.

Next. The goal of care might be episodic, chronic, or quality of life and quality of death, and this patient as a contributing care team member needs to be considered in care planning of all kinds—life and death

Next slide, please. The patient is an important safety checkpoint and largely a very important safety checkpoint today as related to absence of data and transformation for transitions of care.

Next. The patient today asks largely the health data exchange of one, and with that, the lack of standardization presents opportunities for error and confusion.

Next slide. As a contributing care member, the patient is important in shared decision making.

Next. The messages the patients generate are material to care and health.

Next. With every EHR system, there is a patient system reaction, so as we work towards certification in long term post-acute care, it's important to understand that a patient facing system will interact with that as well.

Next. The structured data advances all systems, so as we look at patient generated health data and care planning, advanced directives and such, structured data helps to inform every system in care.

Next. We want to expand and harmonize all of the standards.

Next. And create once and use often, more so in this area than any other place.

Next slide. As we view, download, and transfer, the provider should protect that information, but the patient should continue to be able to direct it, so the work being done in Blue Button would have a great application in transitions of care and long term post-acute care.

Next slide. Orders can be directed to patients and—to some patients.

Next slide. Patients are the only source of adherence information, and patient generated health data included in the record is the important aspect keeping the continuity of care throughout every transition.

Next slide. Data reconciliation should include the patient.

Next. Patient facing systems should not be encumbered by the legacy technology, so as we look to long term post-acute care, let's make sure that we are looking at advances that promote all members of the care team including the patient.

Next slide. Innovation should be encouraged and not limited.

Next. Transactional approaches should be the minimum requirement in this area.

Next. Patient generated data should be interoperable for all settings of care.

Next. Standards should be accelerated where patient generated data is likely, and this area is a high area of patient generated data and gives much of the information about reconciliation, transitions, and care settings in the home help to provide more data to all settings.

Next slide. Next. Vocabularies—we heard about this earlier, standardized and harmonized.

Next. The new design should be with the patient in mind.

Next. Making sure that we look at comparisons in quality across all studies, including the patient.

Next. It helps to proactively identify the care that should be given.

Next. There is great opportunity in long term post-acute care to help with transitions in care, interoperability, patient engagement, and care coordination, and that would be a wonderful minimum first step to help from the patient engagement and patient activation throughout the care setting.

Next.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

My apologies, Leslie; your time is up.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay, thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Sandy?

Sandy Atkins – Partners in Care Foundation

Yes, and I also have slides.

Next. Go to the next one. Okay, so on the next one—I'm sorry, you have my old slide deck, not the one I sent last night.

Next slide. Okay, so the most important thing I want to do is communicate to you all that health happens at home, that the facilities and licensed health services we've been talking about are extremely important, but 75 percent of long term care is provided by families in the home, and by non-licensed personnel and agencies going into the home. This is going to become more important because, when dual eligible go into managed care, those providers are not going to be wanting to pay for nursing homes, so the home is the focus for 99 percent of everything that has to do with health. The technology needs to support consumers and it has to be fast and easy.

Standardization is extremely important to facilitate data entry and keeping the right information and exchanging it. So in this case, I said prescription bar codes, which I could zap with my smartphone, but in addition, all of the data elements that have been discussed earlier need to be standardized in order for us to exchange information.

If you think about any person or patient, if you want to call the person a patient, it's not rocket science. We can standardize this if people are dedicated to doing that. Certification standards need to connect all software used to the home and community to health care providers.

Next slide. This is just an example. Our one agency, which is a nonprofit dedicated to improving health through innovation, we have all of these different programs, all of which use different software systems, all related to the regulations and the billing required by government agencies. None of them are tied to each other, none is tied to health care providers; all this information just kind of drizzles through the net and nobody gets to benefit from it.

Next slide. So we have lost data and lost opportunities to improve care. We're going into the home, we collect a comprehensive medication list, all the adherence information, we do a depression screen, cognitive screen, assess for ADLs, information about falls, dizziness and confusion, all of the questions that nobody in the office has time to ask. How many doctors have access to this information that would help them take care of their chronically ill patients? Almost none.

Next slide. We have an innovation called HomeMeds, which is an evidence-based program that uses software in the home used by social workers, sometimes care givers and individuals embedded in their existing home visits. For example, care transitions, case management. We find that about 50 to 70 percent of the people that we see in the home in the long term care system have some kind of medication related problem that's being discovered by a social worker in the home with our software.

Next slide. What are we finding? Duplications, pain medications, falls—we have lots of problems that are being found. I'm just going to have to flip through.

Next slide. We find all of these problems and they're all missed by the health care system. They've all been—most of these people have been recently hospitalized and we're finding all kinds of problems with the social worker and software that the health care system completely missed, and most of them have had what's called the medical reconciliation in the home.

Next slide. Just flip through this one, this one, this one—those are just pictures of what people face in the home. They have Spanish speakers trying to figure out their English meds, we have complex medication regimens and pharmacies calling patients and saying, "Do you want to renew?" and they're confused and they just say yes, so they have a mountain of medications they don't know how to use.

Now, I'm also a caregiver, so a couple weeks ago, my mom got sick and asked me to put all her medications away for her. She had a Costco sized box full of baggies that had her old medications, her new medications, her as needed—there's all kinds of things. I had no idea what to do. I finally did it and then made the spreadsheet, then two weeks later I'm doing a Part D enrollment for her and I had to re-enter into that system all the medications. Every one of these things is already in somebody's system somewhere; why can't we get to it? The prior speaker was talking about, "This is my record. That's the most important thing; this is all my information."

Next slide. We're going to skip that slide.

Okay, here's a typical medication bottle, it's got three different bar codes—I can't read them. There aren't any national standards across pharmacies.

Next slide. All our folks should be able to go into the home, including patient's caregivers, zap their meds, put it into some kind of decision support tool for themselves, as well as their caregivers, upload the information from the health record that would eliminate 60 percent of data entry, and then put it back into the EHR.

Next slide. It needs to be better. We need to have certification that, as a back end, make sure that we have evidence based knowledge incorporated into the decision support.

Next slide. And all of this needs to be affordable, because most of this care is provided by individuals in the home and by small community agencies whose funding was cut by sequester, trying to take money where we're not allowed to have any IT or indirect costs, and so the take home message is that certification and interoperability coupled with sufficient volume to be affordable to nonprofits are essential to care coordination around the patient needs, across providers and location.

Next slide. And this is just—

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Sandy. I'm sorry; your time is up.

Sandy Atkins – Partners in Care Foundation

Nope, that's perfect. Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Joanne?

Joanne Lynn – Altarum Institute

Hi, this is Joanne Lynn, I'm a physician, long term care provider, researcher, quality improvement advisor. I've submitted some written testimony, so I'm going to focus only on the elements that haven't really been focused on, and I'm especially privileged to follow Sandy, who has helped set up just how complicated these patients are.

Frailty has become the largest source of disability in the country and will become much more as we age. The people on the phone face an average of three years of self-care disability. At that part of our lives, we have very complex situations involving not just medical care but also housing, transportation, finances, family relationships, caregiving—we really have to work on how to deliver the just right services at the just right time for the population and stop thinking first about the different provider categories. The two largest missing elements that we face in trying to do this are the thorough absence of individualized care plans that are comprehensive, practical, move across settings and time, that articulate the patient and family's goals. For example, we almost never talk about the care plan coming into the hospital, we only talk about trying to transfer it out of the hospital, but of course the patient's been sick throughout and mostly is going to have the same things leaving as they had coming in. We also need system management. The CDC person spoke to this, but we also need to be able to see over and undersupply and appropriate distribution an reflect the population's priority needs.

So once you have this population clearly in mind, how does that affect the question of certification for LTPAC? I think that there are three things to take account of. The first is, you have to make clear that the goal is to enable care plans to move across settings and time for very sick and disabled persons. You need to actually ask to change the marketplace and not to assume that the current marketplace constraints are the ones you should be working under. Of course it's good to have voluntary certification as a helpful step perhaps, and we could require or come to require some interoperability of at least a small set of data, the medications, diagnoses, care plans, function, mental status, likely course—that would be my list.

But this is a small step. We need much more bold steps, and especially to notice that care is basically geographic. We need every provider, including the family and patient, within a geographic area to be able to see all of the record. This would likely be less expensive overall; the problem is that the money saved is in the wrong places to pay for the changes, which means that groups like this have to also speak out on changing the marketplace. And secondly—yes, of course, we need to put the care plans into the records. We've put the care plans into the records for hospitals and doctors as well as for long term care providers. We need advanced plans in all records, we need to know who the surrogate is, and not just a yes/no. We need to be able to code the major decisions. These are important everywhere in the system. Third, we need to make the core elements available to the patient, family, and caregiver. These are the most important long term post-acute care providers, so they have to be involved in seeing the care plan, the record, the likely goals and the likely course.

So we have to push ourselves to think about the population. This is going to be the largest population, the most important consumer group, as it doubles over the next 15 years, and we have a set of provider systems and the information systems to support them that are inimical to their well-being. So we must look for interoperability across a geographic area, ensuring care plans are in each record enabling client access—that's patient, family, and caregiver—and use of the information system for managing the system, for managing the supply and distribution and quality of services as well as the public health issues that the CDC person mentioned.

This is a major change in how we need to think about it, but we can stultify the possibility of progress by ossifying the current arrangements with one more set of provider specific regulations rather than starting to look at the populations.

Thanks for the chance to speak at this group.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, Joanne, and thank you to all of the panelists. John Derr has a question.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Yes. Thank you very much. This is a great panel, because it brings in the loved ones and the family. Just one comment to Sandy—there are 2400 senior pharmacists out there that are certified in geriatrics, and I would get a hold of the one in your locality. These are ASCP senior pharmacists. Leslie, I'd like you to finish your comments on the advanced directive, because I know that's something that we've talked about and how to do that. But I think, building on what Joanne has said—and this is one of the things that we've been talking about a lot, and that is, it's person-centric, electronic, longitudinal care is our ultimate goal, and when the hospital gets somebody on an episodic and tries to treat the disease state that that person has, they then go to the nursing home where they have longitudinal care.

So my question to the panel is, how would some volunteer certification help us to get the family—I know in meaningful use, the hospital has to tell the family, well, in a nursing home, and in many respects in home care, the family is the caregiver and has to be involved in their treatment of their loved one and in a nursing home, the loved one is in a home sometimes geographically different. How will all of this come together where we can notify the family and keep the family involved?

So the question is—how do we keep the family, the certification, volunteer certification, how do we do this to get the family involved in our care when somebody might be in a nursing home or in a home care agency?

Sandy Atkins – Partners in Care Foundation

That's for Leslie?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

It's for the panel.

Joanne Lynn – Altarum Institute

This is Joanne; I'm happy to jump into it. I think that we should have, we should really push for a small funded demonstration program that would optimize the transition of records in a geographic area for a population of very sick and disabled people. It's a small proportion of the overall population. We can go back to the HIE kind of model. We can put the care instrument in the cloud and begin to populate it. We can figure out how the family then—the patient and family and the caregiver—can have direct access to a presentation layer that gets to the things that they most care about, and that will be the care plan, the likely future course, the medications and treatments. It won't necessarily be all the records of creatinines back in the distant past.

So we need to figure out what the presentation layer is that is appealing to patients and families, but to have one record that all parties can tap into, upload to, download from, right through to the end of the person's life, and without that, we're all just shootin' blind; we don't know where we're going.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

[Cross talk] Isn't that the EHR? Isn't that what the EHR is supposed to do?

Joanne Lynn – Altarum Institute

It's the EHR plus the care plan, because we don't really have care plans in EHRs, and it's the EHR plus a real advanced directive, because all we say now is yes and no, so we have ignored the fundamental issues for this population. We don't include anything about Social Services, we don't include anything about housing, we don't generally include things about the capabilities of the caregiver. Even the caregiver assessment that is in the back of the care instrument is not present in EHRs yet.

In the hospital, you can mostly afford to really be stupid about what's going to happen in the person's life, but in long term care, you can't. Life is the outcome, and so we're going to have to have some attention to some things that doctors and hospitals have not mostly been thoughtful about. Ten percent of our families have serious interfamily discord with domestic abuse—how often have you ever seen that in an electronic record? How often have you ever seen drug diversion? We're going to have to learn how to really deal with what our families face.

One of my teams the other day went out to see a patient just after a hospital discharge and had to see the person on the front porch stoop because the condemnation notice was stapled to the front door. The house was going to be plowed down in the next week, and no one in the hospital knew that. They discharged the patient after a \$60,000 hospitalization to a home that was going to be razed. I mean, we're going to have to expand our attention to deal with how people live in order to serve this population. There's just no other way to do it.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thanks, Joanne. Leslie, do you want to comment on advanced directive?

Joanne Lynn – Altarum Institute

I wonder if we've lost Leslie.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

It seems like we may have. She did have to drop off.

Joanne Lynn – Altarum Institute

Well, I'm happy to jump in with just a sentence or two. I think that it is becoming actually harmful and dangerous to have in the electronic record only a yes/no on an advanced directive. Now, a majority of states accept the Pulsed—we could readily digitize most of the Pulsed entries, and we could readily scan and attach to the record a real document. We could certainly identify the surrogate in how they were named. That's what you need to have. People going through this part of life, even if they don't have dementia, get delirious every time they get a fever or get a new drug—it just becomes so important to know who you can turn to and what decisions have already been made that it's becoming really a disability to have electronic records that don't have that.

In the VA system, you can call up every advanced directive and surrogate designation right on the front page screen, and it's just crazy that we can't do it elsewhere.

Sandy Atkins – Partners in Care Foundation

This is Sandy. I just wanted to also comment that the absence of any information about an advanced directive could trigger our folks that are going into the home to help initiate one and guide the person to complete one and get it communicated to the powers that be and get it into the record.

M

Also, to speak for Leslie, she's been working on putting in and incorporating quality of life into the advanced directive and not just the turning on and off machinery, but to really say, "What does a person want to do in their life in their later years ...?"

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. I will add that this group already had a virtual hearing on advanced directives, which Leslie was a part of, so hopefully we can send around a link to those materials if people need additional information. Jennie Harvell did have a question.

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging & Long-Term Care Policy

Actually, I was just going to make that same comment about the previous hearing on advanced care planning, and then similarly, the Health IT Policy Committee has heard recommendations from the Standards for Interoperability and Longitudinal Coordination of Care Workgroup regarding the important need for standards for the interoperable exchange of care plans, including the home health plan of care.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Jennie. It doesn't look like any other workgroup members have questions. I can't believe it, but we've actually been able to get everybody in within the limited time that we had, so I just want to thank all of our speakers for their ability to present and being flexible with us and understanding if I had to cut you off.

Larry, I'm going to turn it over to you to see if you have any additional comments before we open it up to public comment.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I'd like to thank everyone as well for the robust comments from both the panelists and the questions from the workgroup members. A lot of really good discussion today; it has been a very long session. I know the panels were sort of all chopped up, but in total, we've been going for several hours now, so pretty impressive all around. A lot for us to chew on and digest as we start to look forward to the recommendations we can frame up, and the workgroup will be picking this up early in the new year to continue the thinking and move this forward, so thanks again to the workgroup.

I guess we're actually ready for public comment.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay. Thank you, Larry, and LaTonya, can you please open it up for public comment—or Caitlin; sorry.

Public Comment

Caitlin Collins – Altarum Institute

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-6006 and press *1 to be placed in the comment queue.

We do not have any comment at this time.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay. Thank you, everyone. We greatly appreciate your participation today.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Happy holidays.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Happy holidays to you, too; thank you.

Public Comment Received During the Meeting

1. What is the correlation between certification and IT support in nursing homes?