

**HIT Policy Committee  
Certification/Adoption Workgroup  
Transcript  
January 21, 2014**

**Presentation**

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Certification and Adoption Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Marc Probst? Larry Wolf?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Good morning, Larry. Mike Lardieri?

**Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Good morning. Joan Ash?

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

I'm here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Joan. 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 for Health Information Technology**

Hi, John. Carl Dvorak? Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Good morning, Paul. Joe Heyman? George Hripcsak? Stan Huff? Liz Johnson? Donald Rucker? Paul Tang? Micky Tripathi? Maureen Boyle?

**Maureen Boyle, PhD – Lead Public Advisor, Health IT – Substance Abuse and Mental Health Services Administration**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Good morning, Maureen. 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 for Health Information Technology**

Good morning, Jennie. And are there any ONC staff members on the line?

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Liz Palena-Hall.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Good morning, Liz.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Hi, good morning.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

It sounds like that's it, so I will turn it back to you Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Great. So I want to welcome everybody back. Yes, there is a snowstorm in DC, but we all seem to have found our way, several of us anyway, found our way to a phone, that's great. Sounds like though we're missing several workgroup members this morning, so, that'll have to be what it is. We're going to pick up the conversation from where we left things on Friday, so we're – the slides that went out are chopped to have no print material essentially and just pick up the conversation. There have been a couple of other minor edits to indicate where the proposed areas for certification are specifically MU2 certification criteria, to further clarify that. And again a reminder to the workgroup that the headings on the slides are taken off of the MU2 classifications for criteria.

There are a bunch of open topics from last time that we're not going to pick up today; we're going to have to schedule some time to get back to them. Both on some of the principles about what we're doing, there are some open questions of some of the other workgroups and a bunch of other things that need attention, but are not going to get it today, so that we can focus on trying to get through the rest of this material. So are we all set, any other – a risk, opening comments from anybody else? Are we ready to dive in?

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

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, let's dive in. So, education – patient specific educational resources, so we were talking about this when we last gathered. Liz, you want to give us a quick snapshot of what was heard at the hearing and then we can pick up our discussion.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

So, we heard from the hearing that 75% of long-term care is provided by families in the home and by non-licensed personnel and agencies going into the home. We also heard from panelists that need to figure out the presentation layer that appeals to patients and families, so that there's one record that all parties can tap into, unload to, upload to, download to, right from – right through to the end of the person's life. That's what we heard at the hearing. I do have one clarification from our conversation last week and just looking at the criteria from MU2 and that is, there was a lot of conversation around the quality of the materials that the EHR could produce. And I just want to make the clarification that the educational resources do not have to be stored or generated by the EHR, and in fact, third party resources such – I'll give you an example, Medline Plus, could serve as the resource to be integrated with the EHR as the source for patient educational resources. And with that, I'll turn it over to you, Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. So, what we've got here is continuing the MU2 criteria, support the ability to use the ONC standards, electronically retrieve patient specific educational materials. So we heard, I would say, a couple of high level thoughts from the workgroup members. On the one hand, questions about the value of those materials relative to printed resources and – I've spaced on the other comment – and the need to actually have information easily available and that in fact, some providers are making use of electronic tools to generate materials for folks. So, any – let's pick up the discussion.

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

This is Joan and I think this is a no brainer. I think especially the way its expressed is very open and it is already being done and there's really no reason that I can see not to include it.

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

This is Jennie and I just wanted to echo that, Joan. I think this is very important, as we spoke about the other day, to support patients as they transition across care settings, as they leave institutional care providers and go to the home, perhaps with home health or perhaps without, making available patient specific educational resources will be important to support their continuity of care.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So in the context of this being a voluntary program and supporting modular certification, is there any reason not to say that this would be part of an area that's of interest to LTPAC? And within the framework of it being voluntary, that this would be an area where vendors could certify if they met the details of the criteria.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and – this is Paul Egerman, to be clear though, if this is included in certification, every vendor has to be certified to whatever the MU2 standard is and I just wanted to also find out, this is only the MU2 standard. My understanding is that for MU3, it's proposed that the material be presented in the sort of like the modality that the patient prefers, so that includes like emails or I guess thumb drives or other electronic approaches, which may be things – it's not like they're hard to do, but it's just its additional work.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm. And so, you actually bring up a good point that while we may be – we only have the MU2 criteria to really work with, by the time the regs come out, they will probably come out in sync with MU3 and so there is a bit of unknown in anything we recommend here, is going to have that problem.

**Paul Egerman – Businessman/Software Entrepreneur**

And the MU3 approach is hard – a bit harder, it's not impossible, of course.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Paul Egerman – Businessman/Software Entrepreneur**

But again, we probably just need to move on, but my view of this is, this is – it's not like there's anything bad about doing this. But I don't think it needs to be included in certification and I think we have to be careful that we don't look at these things like each one sounds like it's a good idea, but then to get it all done, you realize that you've added 10 things that are really good ideas, and now this thing is very difficult for a vendor to get done.

**W**

They're going to do it anyway.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, and if we look at the history of what people did already certify, they've been pretty selective in the post-acute, long-term care space, in what they've chosen to get certified, likely for that reason.

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

I'd like –

**Paul Egerman – Businessman/Software Entrepreneur**

I didn't quite understand what you just said.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

If we look at the vendors, there's – the analysis that Jennie Harvell and Sue Mitchell did, they went through the CHPL and pulled out the vendors that are selling into long-term post-acute care. And there's, I don't know, around 8 or 10 of them that have – some of them are major vendors who have complete EHRs, but most of them are more niche vendors who've done certification, modular certification in general, I don't know if any of them are complete. And they've chosen the modules that made sense to them to get certified, whether it was driven by product capabilities or marketplace demand, I don't know. But they picked and chose the ones that they certified for.

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

This is John Derr, I just, I guess Paul Tang last Friday mentioned just to keep things into transitions of care, not that patient education's not really important, but I think we want to keep it simple stupid type of thing in our certification. And I tend to feel that I think the vendors will do this anyway, because they have been, because as a provider we demand it. So I don't know whether it has to be in certification or not.

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

And so this is Jennie Harvell, since this is going to be a voluntary certification program, and we don't – at least it's not clear to me what the structure of this program will be, I would urge the inclusion of this position because it could be as we talk on other calls, a market differentiator. Those interested want to pursue certification on patient specific education could do so and those that are not interested in doing so or are not ready to do so, wouldn't have to. It would be a voluntary certification program and I think it does communicate a level of I guess soundness or a good – I know there's been a lot of discussion around the use of that term, but it does communicate, I think, something about the quality of the product.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

This is Liz from ONC, is there any – I guess I want to hear other – also from the call. Did we hear from everyone who's on the call?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I'm taking silence –

**Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health**

I'm sorry, this is Mike, and I was on mute. So yeah, I think this is an important component to have in certification, whether it's behavioral health or for long-term care, to provide this information to patients when they leave.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. So I can see when we go back to principles that we need to reflect the discussion about striking the balance and reminding that many good things can be focused and not deliver on the things that maybe are really important. Okay, let's go on to the next one. So, I apologize, I'm not on the WebEx, let's advance –

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

**Paul Egerman – Businessman/Software Entrepreneur**

So Larry, I just wanted to make sure you recorded that – I mean, I guess consensus was to go forward with this, but if I heard correctly, John did not agree and I know I do not agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yes, that's what we heard.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thanks Paul.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Okay, so we're on incorporating lab tests and values. And so what we heard from the hearing was that CDS systems that have been developed use signals that require the presence of admission, discharge, transfer, lab and medication data and that there are existing standards for labs in particular, including LOINC and for medications, NCPDP, and they are widely available at least for support. Also others have said that they have built in some of these capabilities during their certification process and that they are now – these LTPAC providers are now able to import lab results. Other LTPAC providers have said that they have found that sharing these lab results, as well as demographics, have been of primary interest. All right, so that's all I have from the hearing.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. So –

**Paul Egerman – Businessman/Software Entrepreneur**

I just have a question first about this, because when we did transitions of care, I thought the concept about transitions of care was that the – whatever it's called, the CDA, the transitions of care document would be consumed. And so, isn't this separate and sort of like an overlapping capability, that this is really a capability where if a physician orders a bunch of lab tests, those will get consumed into the record also, assuming that the commercial lab is able to send it to you electronically? Or –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Again, so I think the challenge in almost all of these care settings, Paul, is unlike a hospital, they don't have a captive lab, an onsite lab, and so they're all sending it out –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah but what I'm trying to understand is this is not the same as what we already did with the transitions of care. In other words, the transition –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

That is correct. That's correct.

**Paul Egerman – Businessman/Software Entrepreneur**

– of care will also – whatever's on the transitions of care document will also be consumed.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

This is if a physician orders a bunch of lab tests on a patient, separate from in the transitions of care –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– then it goes into the LTPAC record.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

And then the other part I'm confused by is part of what I heard in some of the hearing background was that a lot of these organizations do not employ any physicians.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

That's correct.

**Paul Egerman – Businessman/Software Entrepreneur**

So, if they don't employ any physicians, they won't have any lab results coming in or is that not right?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So no, that's not right. So, it's a good question. So the model is that – well, so increasingly there's more prescribers and ordering personnel onsite, typically in the form of physician extenders, nurse practitioners and things like that. There's some remote use and there's increasing physician presence, not employed necessarily, but present in –

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

Because they all have to have a Medical Director.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and to John's point, they all have some medical oversight and there are requirements for periodic visits by physicians.

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

– especially with Coumadin and some of the others.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And they are issuing a lot of orders, and the orders are carried out typically by nursing staff. So it's everything from they're doing the med administration, and so they have to have a supply of meds. But in this case, we're talking about labs, and so they're ordering lab tests when patients either baseline routine or as patient's condition changes, they're ordering labs to understand what changed. And I think the thinking for bringing this forward is if you're going to create a care summary to send on to the next care setting, that you want to include the lab results in that as structured data, and the only way to get that is if you're getting structured data from the labs that are supplying you.

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

But in addition to the transitions of care, you need to know the lab results in order to effectively manage the care of the individual in this setting, while the person is still in the setting. And so to your question, most of these long-term post-acute care providers do not employ physicians, they're contracted. They do have Medical Directors; the nursing homes are required to have Medical Directors. And those Medical Directors are available in those facilities, but there are attending physicians who are often contracted and those attending physicians will make orders for their patients, just as they would in their community practice.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, and Jennie's saying they're contracted, they also could be they're in the facility, but their relationship is with the individual patient –

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

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and they're billing that patient for outpatient services.

**Paul Egerman – Businessman/Software Entrepreneur**

So in that case, the results go to the physician's EHR and not to the –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

You would – you might imagine that, but historically no.

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

It's an EMR, it's in the facility EMR.

**Paul Egerman – Businessman/Software Entrepreneur**

All right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So they're typically – the facility maintains the medical record for the patient while they're there.

**Paul Egerman – Businessman/Software Entrepreneur**

And it's – in all the different care settings, like home health, there are a lot of laboratory tests ordered and –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, no, good point. So the home health gets fragmented in the other direction, because you have the home health agencies who are doing the hands on care, may even be part of facilitating getting the lab results obtained, the lab specimens drawn –

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

And they work with the primary physician.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– but that is more primary physician focused.

**Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health**

When you would expect –

**Paul Egerman – Businessman/Software Entrepreneur**

In that case, the results would not go into the record –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well –

**Paul Egerman – Businessman/Software Entrepreneur**

– health record, they might have just the transition of care document the nurse might be looking at and some instructions.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

My sense is that they actually typically get a copy of that so they can be part – as part of managing the care. Yeah, in the paper world they do get copies.

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

Larry, so on CDS, I mean that's going to be pretty specific to LTPAC and for it to be successful, you really need this, particularly lab tests in this coded format. So, I think it's a pretty important requirement.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Was that Mike? Who was talking?

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

This is Marc.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Oh, Marc.

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

I've had technical difficulties all morning getting on to this call, so I was late to the call.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Our apologies.

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

It comes with my title.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Of course.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

And Don Rucker, I'm on the call as well. I just – apologies for being late.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Welcome Don.

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

And Paul Tang.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Oh, wow.

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

I didn't get that when I got on Paul.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Wow to the whole collection of everybody.

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

Yeah, it's the collection.

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

Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

It's the growing committee, the invisibly growing committee. I need the remote control screen for the WebEx to see who's actually connecting.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional - Independent Consultant**

And Larry, this is Sue; I'm on as well.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, in case we need a – in case we have a tech question. Thank you, Sue.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

There you go. Thank you.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. So lab – so we clarified what we’re trying to talk about. This is lab values coming from a lab to an LTPAC provider that may be redundant to – going to a physician or may, in fact, be a whole and current process so that it doesn’t go to the physician; it only goes to the care setting.

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

And then it goes – this is John Derr – then it goes to the EHR under transitions of care, the final one, usually.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well, that’s our question, right? Is the data going to be available to put in the summaries, as we move things along? So, the proposed – getting back to what’s in front of us. So what’s in front of us is the MU2 criteria for the system’s being able receive HL7 version 2.5.1, so it’s pretty detailed, in support of having granular lab results.

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

I think it’s important, consistent with the conversation we just had, for all the reasons.

**Paul Egerman – Businessman/Software Entrepreneur**

I can’t hear. Could the person who just spoke, speak up?

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

Yeah, I’m sorry this is Jennie. I’m – if you can’t hear me, remind me to speak up, I have a very bad cold. I was saying that I thought this was an important criteria to include for all the reasons that we just described or discussed.

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

And this is Joan and I echo that. I think missed lab results are one of the biggest safety risks for patient safety, and this may be more difficult than the last one we discussed, but it’s super-important.

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

Yeah, it’s Marc Probst, I would agree with that.

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

And this is Paul. If you look at from the CDS point of view, the high leverage coded data like labs, problems, meds and allergies are things where I think everyone could be helped by, including long-term care.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So it sounds like we’ve got pretty good consensus this is important and we should go forward with this one. Okay, let’s do that. Let’s go on to the next slide. So we now should be on 4, clinical decision support, slide 4, clinical decision support.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Okay, so what we heard from the hearing, we heard that CDS can greatly improve the detection and management of adverse consequences and improve regulatory compliance an inclusion of medication specific – and medic – and inclusion of medication specific CDS should provide alignment with and support for existing federal and state programs. That the level of opportunity for using CDS at the time of prescribing can be quite significant; for example, there’s a clear opportunity to optimize the way antibiotics are being used and other antimicrobials. And that we should think – we should try and link CDS rules to those harm-related events to try and reduce them. Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. So the proposed criteria here is highlighting elements that are in the current CDS criteria. So these are all one piece, right?

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yes, so they would be – they're included under CDS.

**Paul Egerman – Businessman/Software Entrepreneur**

So Larry, my question on this is does this work? I mean, I heard the comment about patient safety, so does this work for hospices?

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

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah. So, hospice is an interesting question, Paul. Often it's used, the last few hours of someone's life, but it's also not unusual for people to be in palliative care, receiving hospice services for months and in fact, having medical interventions happen during that time. But they're not focused on curative interventions, they're focused on managing pain or managing other issues not related to whatever condition is killing them.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, and so that was my question is if the clinical decision support rules are more intended to be patient safety and curative as opposed to maximizing the patient's comfort?

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

No, I don't think they're –

**Paul Egerman – Businessman/Software Entrepreneur**

Do the rules apply? I mean, you're telling me that it is currently being used this way?

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

Yes, there's nothing in the ONC meaningful use requirements regarding – in terms of clinical decision support, that address curative. For example –

**Paul Egerman – Businessman/Software Entrepreneur**

But the – but the comments that were made, and explain this, did talk about patient safety.

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

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

We still want to avoid drugs – the drugs killing the patient. Although you're right, we may be giving them a high dose that –

**Paul Egerman – Businessman/Software Entrepreneur**

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– would normally set off an alarm. So some of this is going to require smarter rules that say, you know you're going to suppress their breathing with this high a dose.

**Paul Egerman – Businessman/Software Entrepreneur**

Well again, my question is what's the state of the art for hospices? Are people doing this for hospices? Do they use a hospice system for the decision support or do they use the primary care providers or the physician's system, if the physician's not employed by the hospice? I'm trying to understand, how do things currently work?

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

I'm not – this is Jennie again and I'm not familiar with the literature on the use of clinical decision support tools in hospice. I'm sure it's knowable. I'm sure there are certainly palliative care experts that we could reach out to and find out some clinical decision support tools that are being used in that setting.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I guess what I'm hearing from you Paul is we need to clarify whose system is actually doing the work in the care setting or in the, it might not be a physical care setting, in the virtual care setting. So to your point, is it really a physician's system that's already covered or is it some other system that we're imagining is doing this job, but in actuality, is this involved with med orders but might be involved with the med ordering. So it might be involved with other aspects of med management. So there are things we heard about the value of monitoring –

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

I think we're going to find that it's both.

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

Yes, exactly.

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

I mean –

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

And I'm sorry, hearing Larry's comment; I didn't understand the nuance of the initial question. But, for example, hospice services can be delivered in a nursing home environment, just for example. They can also be delivered in a home setting as well.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes and this is Paul, I understand that. One suggestion I might make for something like this where they probably have sort of like this problem of one-size-fits-all – about something like this, that it might have great value in some settings, but have no value in other settings and as a result, the vendors who sell to those settings might have trouble with it. So one approach might be to make this an optional certification criteria, in other words, to sort of say that not every vendor has to include this capability, because this is a complicated thing to do.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I guess what I'm hearing is, when we get back to crafting how to interpret the overall recommendations and what does it mean to have voluntary and what does it mean to identify areas of value to a care setting that there is variation among the care settings, which would affect what systems they actually have. And that we should be careful of not pushing vendors to include things that are not relevant for their setting, but on the other hand, to Jennie's point, a lot of this care happens in a variety of settings. The hospice unit might be a unit in an acute care hospital, and they might be using the acute care hospital's system, which would already be covered, although there might be a carve-out for that one unit, not being within the acute care hospital. So, don't want to get into the nuances of the regulations. I think we need to address that in our overriding comments about all of these.

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

I think it's done, I think part of the challenge with this is there are potentially some very separate tools that are coming into this box, so you could think of sort of rule-based expert systems where you're supporting a rules engine. The link to referential could just be a series of URLs, honestly, probably presumably firing off rules, but not necessarily. And then you could imagine the drug-drug and drug allergy are coming off sort of software of service or some more externalized interactions and so there are almost certainly going to be separate databases. So I don't know how we put in the different nuances of all the different ways that you could put in clinical decision support. But, it's a pretty heterogeneous set of things, unlike, for example, the prior topic which was covered somewhat straightforwardly under HL7.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, so I think this is actually part of the broader discussion about are we looking broadly at aspects of health IT that deliver clinical services. Or are we looking narrowly at, I have this thing that I call my electronic medical record and I have put boundaries around how much technology I want to have in it as opposed to in these other offerings. And hopefully the strength of modular is that there are some options there.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, but – this is Paul. But Larry, modular is not the same as what I'm suggesting as optional certification. This is optional would mean that a vendor who's a home health would not necessarily need to include this and still get certified.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And I guess the question is, are you suggesting or are you thinking that ONC is going to come down to having – if you're in this setting, here's the criteria you need to have a system in that setting? And they very –

**Paul Egerman – Businessman/Software Entrepreneur**

No, I don't think ONC is going to that, because I think that's complicated. As you said, there are a lot of overlaps between the settings and it's going to get even more complicated, I suspect, when we get to like behavioral health, where there's overlap between behavioral health and LTPAC.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Paul Egerman – Businessman/Software Entrepreneur**

So – and I don't they should do that, I just think that if we make it optional, then you make it possible for vendors to get certified without the functionality and to me that's okay. Because they'll do all the transitions of are, they can do the last thing that we talked about with the laboratory stuff, and that's a strong statement about the capability in the product.

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

So, I'm sorry, we're kind of, I think, going into a broader conversation, or maybe the conversation that comes at the end, but it sounds like you're suggesting that there would be a core component of this voluntary certification program and then –

**Paul Egerman – Businessman/Software Entrepreneur**

Well that's my understanding of how the whole thing works, I mean the materials that were presented to us sort of showed that there were these two steps and you've got to go through the first step is you test everything. The second step is a certification group looks at all the test results and gives you thumbs up or thumbs down. And so – and we've already done this, right? We've already approved some things that included an optional certification, which was accounting of disclosures. We already done one situation where there are a whole series of things that were mandatory and there's one thing that was optional. And I just think that if you provide for a few things that are optional, we can create the flexibility to do this. Because everything else that we've done is, we've said the new generation of quality reports has to be included. So I interpreted that to say, that's a requirement, you can't get certified unless you do the new generation of quality reports. You can't get certified unless you do the last thing we said the laboratory results.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. So –

**Paul Egerman – Businessman/Software Entrepreneur**

Unless we say it's optional, I assume it's mandatory to get certified.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, my understanding of the way the certification process works is the certifiers are actually confirming the modular test results or the complete test results, that the certification by itself is still at that level, it's either complete or modular. Liz is shaking her head yes, it's her understanding of this.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yes.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, I am as a matter of fact. So –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Oh, and the other Liz is now on.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Oh hi, yes.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Oh, I'm sorry.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yes I am.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

This has really been the stealth committee meeting – workgroup members for joining us.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

I'm sorry, I was just listening and then I got on the website to see what you were looking at, because I'm like, what are they talking about. I'm with you.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. So, maybe this is important as we continue is that when we talk about modular, that's modular certification and the modules are, at this point, still freestanding and we haven't bundled them together into anything. But we're assessing the set as these have high value – we believe these have value in the care settings, either because they're important to safety and patient care in those settings or they're important to transitions of care.

**Paul Egerman – Businessman/Software Entrepreneur**

But for somebody to get certified as having a complete system, unless we specify something's optional, they have to complete every item.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

That's correct. Complete is different.

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

But hold on one second, on your last statement, I don't think this workgroup has yet determined – well, I mean, is that the story, every module becomes complete?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

No, no, no, no.

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

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

That's the question, right?

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

So we haven't –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I jumped to a conclusion, maybe it was not a good one, but I jumped to a conclusion weeks ago that we were not going to have complete certification for these care settings, that the settings were too variable we don't have the time. There isn't time in the current framework that's been proposed for regs, for the kind of rigor that would be needed to create complete. There are a huge number of settings, as everyone's been pointing out and so my personal thinking has headed to the conclusion of, we will be recommending modular certification and these are the modules that we believe are important.

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

So I guess on this one, would we want to certify a product that couldn't do drug to drug or drug allergy checking?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well, the current certification modules allows that to happen.

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

But that wasn't my question.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well –

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

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So then it seems to me it becomes – this underscores the need for an informed consumer, i.e. an informed provider. A provider who can understand what they need in their setting and what technology is needed to support what they need in their setting.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I guess in support of that we've said, there are problems, the whole discussion, both at the full Policy Committee and among the workgroup members is, the need of the smaller providers in this space to get better guidance.

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

Absolutely.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And again, I guess I need to think out loud more instead of inside my own head. My thought was that by having a modular framework, we could be saying collectively, these things may be of value in healthcare, that's why ONC has this program, in addition to the meaningful use payments. And we have made some specific recommendations around what's of value in this space, LTPAC and behavioral health, but we don't propose that it be seen as necessarily complete. And so there's a nuance there, and there won't be a single check these seven boxes and you're done kind of thing, it will be there's a bigger list of things you might have in your EHR.

**Paul Egerman – Businessman/Software Entrepreneur**

Larry, what's stopping people from doing that right now? I'm confused.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Nothing. Nothing, we're providing –

**Paul Egerman – Businessman/Software Entrepreneur**

Do we need to have the rest of the meeting then, we just say – do modular certification based on whatever they think is a good idea in MU2? And I'm confused as to how this all works.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I think the intention was for us to make a pass and be able to say, we think these things are of additional value. And you're right that there might be some perceived arrogance in that that we're getting out there and saying, these other than those, but we'll get feedback from the marketplace.

**Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health**

This is Mike; I would agree that the way you're thinking, Larry, especially for behavioral health, because there are so many different providers, not everybody needs everything. And some providers just need the dif – two or three modules, and that'll let them do their work. So I agree with that thinking.

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

This is Jennie and from the long-term care perspective, I completely agree. And also, I really believe there is – there will be a continuing need, particularly for the small provider, to receive education about these modules and their utility in their space. I think there's a large degree of unawareness, lack of information by the long-term post-acute care provider community, particularly the smaller providers, about even the HITECH Program in general, EHR certification in general. Complete lack of awareness about this Certification Workgroup activity, so I think when rules are finally published about this, I think that'll be one-step towards informing the provider community. But I think that there will be a continuing education need to follow.

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

I agree.

**Paul Egerman – Businessman/Software Entrepreneur**

So at least, Larry, in terms of your vision that you're just – then we're making a decision, for example, that clinical decision support will be a module that one can certify – separately certify to.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, I would hope that how this all plays out if it does go forward is when a provider goes to the ONC website that has the certifications, the little boxes on the left as it did under Meaningful Use 1, identified which components the EHR actually was certified for. Because then it would be easy for the provider to say – to pick between vendors which ones meet their needs actually.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

At the risk of having a knee-jerk ability to pick between vendors, I have the same knee-jerk as to seal of approval. It will help as one aspect, and I think it has to be part of the –

**M**

(Indiscernible)

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Were you going to say something else Paul?

**Paul Egerman – Businessman/Software Entrepreneur**

No.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So hopefully this conversation has simplified the challenge of, it's less an absolute statement that we're heading towards and more a relative, yes there's value here. And to our earlier discussion, if ONC and CMS are serious about looking to improve interoperability, that better be the things that they focus on because it's very easy to get distracted into all these other areas that are also important and in fact, providers have to make decisions about where they put their resources. And –

**Paul Egerman – Businessman/Software Entrepreneur**

But I think it's very important that our recommendation includes this concept that you're describing now of the modules, that there's not an expectation that there will be very many vendors who will get complete certification.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. So having said all that, do we have a sense of the workgroup that clinical decision support is one of those things that would be of importance?

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

This is Joan and I haven't spoken up but definitely, I'm in favor of this.

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

This is Jennie, I agree.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

This is Mike also agree.

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

And Paul agrees.

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

Marc Probst agrees.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Liz Johnson agrees.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Yeah, Don Rucker, I agree.

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

And Larry, did you say this is a menu or "core?"

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well since there is no MU, there's no Meaningful Use Program here. I think we're just saying this is important in this space.

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

Okay, thank you.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And I think that's as strong as we're going to be able to say given –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, so as I understand it Paul, what we just decided is, if the vendors want to get certified for this, they can.

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

And that's it.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, and I think there may be some informing color of this commentary coming out of the hearing and some of our discussion that says, I'll risk putting my foot into the morass here, that other – that there's been an inference that CDS is mostly about ordering and that the ONC initial rules around CDS were very broad. You get to pick the area that you were interested in and find rules that make sense for you and that that applies in this space as well. Sometimes the ordering applies a lot, but also might be clinical decision support around monitoring and change of condition becomes the important thing. You have a lot of lower skilled workers entering data, some smart flags to the supervisors that said, hey, there's a trend here, pay attention, might be helpful. Okay –

**Paul Egerman – Businessman/Software Entrepreneur**

It also strikes me with this new approach, Larry, the ONC doesn't have to issue an NPRM or anything, people could just start doing it to help – MU2 stuff, if they want.

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

Well, I think the problem with that is that at least for those – at least some of those long-term post-acute care providers that have heard about MU, the Meaningful Use EHR Incentive Program, they say, oh, that doesn't apply to us. We don't have to pay attention to that because that's only about physicians and hospitals. And so relying only on the MU Program as enabling everybody to move forward here, I think that's the drawback there is that people say, oh, that's only for physicians and hospitals.

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

Well interestingly, since this is all “voluntary” and all “modular” or menu, this'll be – it'll be interesting to see what the market deems to be “core.”

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

It will be very interesting.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah. No, I think – yes, I'm hearing that sort of around the room here, where I am with several folks, but, I think that that's actually building on what's there and I think some encouragement actually that just because you're not getting paid, doesn't mean that these might not be a value to you, through the regs. Because sadly, all of healthcare is completely reg focused, maybe not completely, it's heavily regulation focused. And when people go, oh, this does apply to me, even if it's voluntary, even if it's optional, I think it's really helpful and I think we've seen the vendors feeling that pressure that they may not be under pressure to have a complete EHR. But they are under pressure to say we're like those acute care guys, we understand you historically and we understand that the certification program does apply in this setting and you need serious products that can handle structured documents that can handle standards-based labs and meds. And we agree and we're taking steps in that direction and the proof is that we've gotten modular certification.

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

Well one of the –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I also think it puts an interesting twist on how ONC looks at what's in the CHPL, because I know it was a fair amount of effort to identify the vendors that are selling into the space. And so if you say, we're trying to look at adoption and uptake in a space, how do we even know what vendors are playing in that space?

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

Well, just as a – I completely agree with you, except you can't go to the CHPL to find out about adoption and uptake. You can eventually –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

It's not by design.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging, & Long-Term Care Policy**  
– yeah, but you can eventually search and find who might be certified by looking at the CHPL, but that's another gap here that needs to be addressed is actually tracking adoption, because right now there is no mechanism to track adoption of certified products, or any EHR product for that matter.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So we've seen some reporting from CMS that suggests that they're doing some of that, at a macro level.

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

There is no good data source at CMS or elsewhere.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, but they have been reporting to the Policy Committee on – or maybe it was ONC reporting on the percent of providers who have systems from vendors –

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

Well, but I'm talking long-term post-acute care.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

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

Sorry, sorry, sorry, correction.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And to Jennie's point, so getting back to Jen – well, now here's Jennie's point of, there's no coverage of LTPAC, behavioral health or any of the other settings. The very last slide talks about doing better surveys and that could be part of the better surveys.

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

Right.

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

What's also nice about the program, Larry, and you probably said this is, this is automatically aligned with meaningful use, as you know, that's the goal for many of the CMS programs, to align with each other and meaningful use is one of the things. But here you're at least making, if you do this voluntary compliance, then you're also helping the – your customers, the LTPAC, behavioral health, that they're getting a system that talks to the other systems.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes and I'm being reminded that we should pay attention to the time, because we've got another 11 slides to go.

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

Yeah, but we don't want Joe Heyman to feel bad that –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Oh, you guys are killing me today, at least everybody's laughing about it. Okay, let's move on, next slide, clinical health information.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Okay, so what we heard from the hearing was that there are CMS documentation requirements for an annual comprehensive med review, and that this structured document contains the pharmacist's reconciled active med list, an allergy list, indications for active medications and special instructions for the patient. And that these can be used by the pharmacist and other healthcare providers in all practice settings including LTPAC and behavioral health. We also heard that it would be good to have voluntary certification as a helpful step and that perhaps we could require some of – a small set of interoperability data to include medications, diagnoses, care plans, function, mental status and likely course. And that's it.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, so, don't want to lose the thought. So, on the proposed areas of certification, we've pulled out the criteria that address problem list, med list and med allergies, as well as then incorporating information that information in support of reconciliation. So it's a – we're sort of feeding into the use side a little bit, in addition to supporting electronic notes. One of the things that isn't on this list I think we should look at is, I believe it's part of MU2, that one of the CDA document types supports functional status, or am I off.

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

The summary of care record requirements includes a requirement to include functional status and cognitive status, if known.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, it might actually be relevant to this list of related criteria, to bring that in. And this is a good example where the heading is really, broad, but the criteria are actually pretty focused.

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

Although the reason for this heading and the reason for the list of these items, problem list, med list, med allergy list, is that that aligns with the MU2 requirements.

**Paul Egerman – Businessman/Software Entrepreneur**

And so – this is Paul, one question I don't understand is, is all this together then going to be one module?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I don't know how they're – that's a good question; I don't know how they're currently grouped. I believe that these are three separate things.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

(Indiscernible)

**Paul Egerman – Businessman/Software Entrepreneur**

But is that three modules? I mean, that's why I was asking, it just strikes me – electronic notes is different than like problem list and medication list.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

So maybe if somebody wants to do the first one, but doesn't want to do electronic notes –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sue?

**Paul Egerman – Businessman/Software Entrepreneur**

– or perhaps vice versa in home health, where the notes might be very important –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sue Mitchell, you're on and you poured through this, do you have a sense of, are these all separate criteria?

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Yes, and that's what I was going to jump in and say Larry. So, the way that they structured it under MU2 was that they actually pulled in the requirements around problem list, med list and the medication allergy list. Under the transition of care requirements for a summary of care record, it's under the create area – or separate from the create area, but it is part of the body of requirements under a summary of care record for transitions of care. Now the ability to do an electronic note is a totally separate requirement, it sits outside of that block of information.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And the –

**Paul Egerman – Businessman/Software Entrepreneur**

And this little bullet, clinical information reconciliation, is that also a separate module?

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

That would be correct.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay. Because it does strike me that if the pharmacist does it, I'm not sure that it's necessarily in the record.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Well, and again, when they talk about clinical information reconciliation, it's more than just reconciling your medication list; they do look if they need to reconcile the problem list, the med allergy list as well as the medications.

**Paul Egerman – Businessman/Software Entrepreneur**

Understand.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I'm hearing that there likely could be the reality of some of this reconciliation actually happens by ancillary providers in ancillary systems, particularly in these care settings. So it's a complication in how applicable it might be.

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

So generally I think this kind of information is needed, not only for summary care records, but generally for – at times of transitions of care, but also for the ongoing management of the care of the patient in the setting or by the provider.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And, they're certainly critical for the initiation of care in a setting, these are top of the list things and we need to get these right to pick up the care for this person.

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

And the reconciliation of that – this type of information from one setting to the other –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

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

– during a transition is very important.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah. Umm, I'll risk throwing in some complexity. Technically the acute care hospitals and the docs have this problem, but it often gets ignored, is they are dealing with a specific acute event or a specific medical specialty and they don't do a broad-based reconciliation. They may even do the reverse in a hospitalization; they may purposely take you off of a lot of meds in order to manage some acute flare-up, but not necessarily address what to do maintenance as you go forward, having fixed the acute flare-up. So there are often gaps in – as patients transition, the next care setting might actually need more information than the prior one had –

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

Correct, and –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and needs to reach back into the history or out into the wider community.

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

And in some research that we've done we've seen exactly that where a person's – nursing home, for example, following a hospital stay, still wants with their electronic information system, would like to be able to reconcile the med list. But they have only, in the best scenario, the medication list that the individual was discharged with or on from the hospital and what the individual was taking prior to the hospital stay is not made available to the nursing home and they do have to search through other sources, to find that information.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I guess the relevant piece here is, these are still emerging areas of practice and even having a reconciliation capability is not – doesn't mean that you necessarily do a complete reconciliation, because the information may not be there, you may need to gather it from other sources; not a problem unique to LTPAC. Okay, so given that we sort of flipped from a sense of modular versus complete as the goal here, maybe I should look for dissenting opinions. Are there dissenting opinions about these being important areas that we should capture before we move on?

**Paul Egerman – Businessman/Software Entrepreneur**

I'm not sure I know what you're asking, Larry. I'm assuming that this is just a module, it's not required –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

– to be done, so, as long as notes are separate, because I just think notes is – it's just different than the others. And so there might be reasons plus or minus in some setting to have notes, and then just like there might be reasons like in home health care where this reconciliation might not be done. As long as they're separate modules, I'm okay with it, and it's not required.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Great. Let's go on to the next one, patient demographics.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Okay, so what we heard from the hearing that was that exchange of demographics and using some of the ADT standards have been of primary interest.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And so we roll forward the MU2 criteria for record, change, access patient demographic data to ONC standards.

**Paul Egerman – Businessman/Software Entrepreneur**

And, this is Paul. The question I have about this is, isn't this duplicative? Doesn't – we already made statements about the transition of care documents and the implementation guides for those already provide requirements for what the data's supposed to look like. So why do we need this at all if we've already done that and then so we're going to be doing the quality reports, they're also going to make requirements on what the data needs to look like. It just seems like – although maybe there's a difference between the ONC specified standards, if ONC is specifying a standard different than what the HL7 standard is.

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

I think the reason – at least the model that was followed here was, in part, not completely, but in part we looked at what was in the ONC MU2 rules and there's a patient demographic requirement in the MU2 requirements, in addition to the TOC requirement.

**Paul Egerman – Businessman/Software Entrepreneur**

Well – I mean, mind you that may be, but if you put forward a standard that says, for example, what a date of birth is going to look like when you receive it and what a date of birth is going to look like when you send it out, I think that's all you need to do. You don't have to put forward a requirement for what it's going to look like when you enter it, I mean the vendors will figure that out.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

So, this is Sue and just real quick, again, the demographic standard, the requirements are straightforward, they say you have to be able to record, change and access patient demographic information. They do call out probably about a handful of specific items, preferred language, sex, race, ethnicity and date of birth, because those are explicitly required under the meaningful use requirements. But I don't think there's anything shocking about systems going to be able to capture those data items. I think just one little tidbit from years of working on HL7 with functionality requirements, the ability to change demographic information, that gets to be – can be contentious sometimes about how you do that, and holding on to old information. It's not specifically addressed in the CMS, but again it does identify that you have to be able to change that content.

Otherwise, as you were saying, the requirements under the transitions of care do pick up the fact that there are vocabulary standards for capturing race and ethnicity, they point to the OMB requirements and then there are requirements from ISO for preferred language. So –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I guess there's a question, this is maybe the minimal version kind of question of demographics in some ways are so basic you have to have it to know who the patient is, so we really want them to be right. On the other hand, they're so basic and widespread that maybe it's not a big deal and is redundant to the other sections, that's where I'm hearing the question.

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

Well I think it's not just the summary of care, the TOC requirement talks about creating a summary of care document for transitions of care. And the ONC MU2 requirement talks about the ability to record, change and access demographic data. So I think we're talking different applications –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, they're different functional areas and different applications, I guess; the other argument would be it's not that these are covered in other areas, but these are so basic that how could you not have them. The only counter-argument I have, and it's really an open question is, not all the vendors who got modular certification did demographics. So we have a market voice saying, they're not – either something in the criteria is a problem or it's just not worth the effort to get this piece certified or I don't know – I haven't actually gotten specifics back from the vendors.

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

I think that's a good question to seek public comment on.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

And, this is Mike, from the behavioral health side, we need to do demographics, the problem we have with this is these demographics are more limited than what SAMHSA requires. Behavioral health providers actually report on it, a larger set of demographics, but that's the only issue.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well, and that may actually be what was driving these vendors to not delve into the ONC certification, their demographic piece may be sufficiently robust to support the mandated assessments –

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

– the downside.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, any comments from the quiet members on this one?

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

We're good.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, my take is, this is important but it may be redundant or duplicative.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, I guess I'd say I'm not opposed, I think it's redundant and while it's important, it is so basic that I don't think it's necessary to do.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Paul, I was actually expecting in the end you would come down on the other side of this because of the patient identity and privacy, security implications that we need to get demographics really right.

**Paul Egerman – Businessman/Software Entrepreneur**

Well you do, but again, I think they're defined already. I mean, I think that demographics are defined in the other documents, I mean, in the information exchange implementation guides and that doing this could possibly be limiting in some ways so –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sure, I got it. So, I'm actually thinking there might be some guidance to ONC that as they look at updating requirements that they look for areas where they've got duplicate requirements and this might be one of them. Okay, let's go on. We need to get focused here.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

So, advanced care planning. So what we heard from the hearing was that we need advanced care 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. We need to make the core elements available to the patient, family and caregiver. And one panelist said 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 accepts a POLST. We could readily digitize most of the POLST entries and we could readily scan and attach to the record a real document.

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

Well, I guess I'll start. This is Jennie. Many individuals who receive long-term post-acute care are elderly, frail, medically complex and have advanced directives and their care providers need to know that those important documents and directives exist.

**Paul Egerman – Businessman/Software Entrepreneur**

Well – and this is Paul, I mean first Joe Heyman sent out an email where he said he's opposed to this and I think part of his reasoning was, well gee, it's not necessary that absolutely every entity have this. And in some sense, it makes sense that an inpatient setting would have a patient's advanced directives, but I'm not sure a home health group needs to have it. And it might be a little frightening to the patient, you get some home health group that their just there to change bandages or something and they need to have advanced directives to do that. So, I – it makes sense though in some settings, we just have to realize the complexity of the situation, it's not the case that every provider should have the advanced directives on file. It's also not the case that LTPAC is only elderly people, there could be children involved and so this – those are my comments. As long as it's a separate module and vendors aren't required to do it, I don't have a problem with it. But those are my comments.

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

Yeah, again just to follow up real quickly. The MU2 requirement is – doesn't force anybody to have an advanced directive, it's just enabling the user to record whether a patient has such a directive.

**Paul Egerman – Businessman/Software Entrepreneur**

Umm, I thought it did a little bit more, it also had to actually record the information in the advanced directive, record a link to where the advanced directive was, is that not right?

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

That's 3, MU3 does.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, MU3, okay.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, MU2 does not.

**Paul Egerman – Businessman/Software Entrepreneur**

And – but anyway, I understand that it doesn't require the patient to have one, but you still are requiring the computer system to have all those different capabilities and I still think that there might be some vendors – health system who don't think that that's needed in their software package and their product.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So as a provider in this space, this is the very first question our clinicians bring to me when I talk to them about improving information exchange. It's interesting, it's even ahead of the labs and meds and things, because they want to know what to do if the patient has a sudden emergent condition, what are the guidelines, who do they contact, other than call 911, do they have other options that have already been discussed with the patient?

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

It's Don, I think it's also important to realize that this is an area where there's probably a lot of other, and will be over time as everybody's getting older, a lot of other legislative initiatives. So this may be the one area where scanned documents in PDFs and things like that have a bigger role than in some of our other areas. So, it may just be that you have a sort of document placeholder for this, as opposed to a lot of structured data.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm. Yeah, I think the structure becomes when it turns into orders, and then they become orders. One of the things that we heard in our hearings back when we did the hearings on advanced care plans, which has not made it into what the MU group has proposed for Stage 3, is the use of repositories, which Joe was referring to. User repositories and links rather than putting the document into the EHR or primarily putting the document into the EHR, you might want to save what you knew, if you're paranoid about whether the repository will be available in a year, when someone asks you why you made your decision, you might want to save a copy. But I think if we're going to have additional certification here, we should remind the MU Workgroup that our hearing included the emerging use of repositories with links that could be embedded in the EHR.

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

So Larry, this is Paul. This is – it's a very good point and I think as you know, the Meaningful Use Workgroup is very supportive of having this information available and maintained and up-to-date. So the notion is that we would have the capabilities, the fields, in the EHR to both point out whether it does exist and if so, hint to where it may be, or links to the actual documents in these repositories. We couldn't – we didn't feel like we could promo – I mean, repositories are certainly outside the scope of the EHR Incentive Program, we were just trying to build in the pointers in EHRs, the pointers to those places. So we don't have a way of making these repositories exist. As you also know, there's a lot of variability in everything from the AD and repositories and POLST or MOLST are out there, so it's emerging. And so we're just trying to build in the ability to accommodate whatever does come out of all of this. Does that make sense?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

It does make sense and I guess the piece that I was missing Paul was I had the sense from what we have here and what was talked about – oh, okay, I take it back. It does have to provide a link.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Well yeah, – this is Liz, Larry. The MU Stage 2 is just what is required on the provider side is that we have an indication that one exists. And one of the things we're not talking about and it's not really relevant to the specifics of how you do modular certification, but it is relevant to thinking. One of the reasons that I'm sure Paul and others have had a lot of pushback is keeping the advanced directives current.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

And I can tell you on the Implementation Workgroup one of the conversations that we've had on numerous times is around our really ability and desire both to ke – make sure we are following the latest advanced directives. And that was one of the reasons why as, and I wasn't privy to all the conversations obviously the Meaningful Use Workgroup had, just because I didn't listen in, but it's a link, it's showing there is one, it's not the actual document; you are understanding that, right?

**Paul Egerman – Businessman/Software Entrepreneur**

Well this is Paul, but what you say is "or" condition for a vendor becomes an "and" condition when you do certification.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Well it's an indica – what the measure actually says is there will be an indication of an advanced directive recorded, not that the advanced directive is contained within the record.

**Paul Egerman – Businessman/Software Entrepreneur**

Well that – I've got something on the screen that's written in red right now, so I'm confused. Are we approving what's on the screen? There's something red that says –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right, that's –

**Paul Egerman – Businessman/Software Entrepreneur**

– support the ability to store advanced directive document or provide a link. So from the vendor's standpoint, that means you have to be able to do both. The next bullet says, you've got to provide – retain prior versions –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– or enable links to earlier version –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– which again, from the vendor's standpoint means you have to do both.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

So, is that what we're saying, that you have to store all these things and the prior versions –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah –

**Paul Egerman – Businessman/Software Entrepreneur**

– you have to retain them?

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Paul is asking the same question I'm asking is, because it's not about – is that what you're – the intent is, Larry?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So our – so, as written, yes, the intent was address either to support both, to Paul Egerman's comment, that makes it – it compounds the problem for the vendor, does that automatically means they have to do both or does it mean they can be an "or – "

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

No.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and what do they do for their providers who are faced with –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Well that's the –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– I have a hard copy; I need to scan it, thank you very much.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right. I think what Paul is saying and I'm concurring is that if you put an "or" in a certification criteria it's an "and" for the vendor, there is no question about that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yup.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

For us there's an "or," for the vendor it's an "and."

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

Is th –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. And I guess the question is, back to Paul Tang, is this even the current wording as coming from MU?

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

Yeah, I don't know whether Michelle's on, but, the first bullet is consistent, that the one, the mandatory – the provider behavior, the mandatory is that there is an indication of yes or no that I'm aware that it exists or not. The option for the provider, but mandatory for the vendor is to support the ability to either have the document stored or a link to some repository. Now I'm – if Michelle's on the line, I don't know about the second bullet, the whole version thing, I don't know whether that's in our, and I can try to look at it for right now, but –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I'm getting a headshake from one of my ONC –

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

No, it's not, it's not in the MU recommend – or identified criteria.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

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

Yeah, I didn't recognize that, but – so, not sure where that came from.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And the same thing for the future work piece it's not either.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

So you're saying it's not included – Paul Tang, you're saying it is not included in Stage 3 recommendations today.

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

The current draft recommendations do not include the versioning.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

But it does include the storage?

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

Correct.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Okay.

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

So the mandatory presence or absence and the ability to store that document one way or another, either as the PDF is generally what it'll be, because you want to see the signature, or the pointer. And we're just hoping that those things emerge so that we have a better chance of getting the most up-to-date, better confidence that you have the most up-to-date version.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Paul, when you did that, was there a sense of – that there might be any differences in state laws, since it think this is a state law as opposed to a federal law –

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

Yes.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

– things that need to be accommodated? Because I could imagine state legislatures reacting all over the place to this and that's sort of been my experience clinically that these things sort of vary by state.

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

That's right, so this is all permissive. So the only required behavior is that you indicate your knowledge of yes or no, and then our accommodation for both state law and the currency of it is the storage with the date and time stamp and/or the link to some repository. So that does not violate any state law and it accommodates whatever you may have in your jurisdiction.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Yeah, that's very nice; I mean that's a very helpful thing when you're trying to figure out somebody who's brought in coding what to do.

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

Right. So we hope, and there were some indications of some mature states that are starting to stand up these repositories, I still have no idea how you make sure they're up-to-date, but at least the date and time stamp will help. I mean, this is all just a human process and it'll help the provider understand how recent was this – was the latest attestation, etcetera. And then we just have to develop both laws and expectations and education and culture to have these things maintained.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, I think the place where we ran into a very protracted conversation about it was, and Joe was certainly part of it is, if there are more than one of these out there on a single patient, how do we reconcile? And I think Paul, we landed on the same place where you are, which is the human part of it, which is engage the patient and if possible, if the condition of the patient allows, to engage them and/or their support system in verifying this is the latest one. I mean, that's all we can do, right?

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

Right. Somewhere along the line we have the date and time stamp, I thought, but anyway that's, of course, one of our biggest hints.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right, but I think it was the matching of what the provider had, what the long-term care provider had and what the acute care, and the settings go on and on, but you get the point.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay –

**Paul Eggerman – Businessman/Software Entrepreneur**

So this is –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– I have a process question to toss out at you guys is, we've got 7 minutes until the end of this, we have 7 slides that we haven't touched.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yeah, so, is Michelle on?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Can we run over?

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yeah –

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

I'm sorry, I'm on another call, I think I heard my name.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yeah, you did.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

I'm trying to multi-task, but not very well.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Asking permission if we can run over?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

I think we can run over, but Altarum, can you confirm? Give us a minute so Altarum can check with the operator and make sure that is okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And we'll need to get focused as well, because even if we run over, we really have to get these done today.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yes.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

It looks like we'll be okay, so.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I'll give us a half an hour of run over and let's not use it.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Okay. Thank you.

**Paul Egerman – Businessman/Software Entrepreneur**

So Larry, this is the other Paul and I'll just say, I heard the other discussion, but this bullet about the versions, I think we ought to drop it, we shouldn't be doing something that's inconsistent with what MU3 is, that would be, I think, problematic.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I think you're fine.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Let's drop it.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Med related criteria.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

The next slide. Okay, so what we heard from the hearing, we heard the practice of prescribers entering orders electronically into the EHR will decrease the chance for errors in the interpretation of prescriber orders. A significant number of orders are changed today verbally or via telephone in the LTPAC setting, keystroke errors are frequently identified in the LTPAC business as contributors to adverse events that result in patient harm. And finally, that pharmacists electronically accessing and exchanging clinical information in these settings are vital to meeting institutional quality and safety medication management processes. Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, we pulled – these are actually three different areas, right –

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yes, that's correct.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– of certification? So there was a question last time about EMAR, so this is electronic medication administration records, so this the documentation side of a med being given, which often happens by the staff in these care settings. Electronic prescribing, which is problematic sometimes because the workflow involves often an off-site physician, who is giving verbal orders to nursing staff who are completing things or in the case of home health, who is sending orders to – perhaps e-prescribed orders directly to the pharmacy, outside of the loop of home health. And finally, drug formulary checks really apply mostly on the ordering side, to make sure you get it right, and often a big deal for patients when they have to look at paying for these things. So, yes, these could spill out into very different areas.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

So just one quick question on EMAR, the reg says technology-assisted, many people have interpreted that as bar coding. Are you thinking more that the record itself, the list of medications, would be produced electronically? Or are we thinking about a closed loop or is that too much detail for this conversation?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Umm, I think it's a really important point. So, the fact that the EMAR is really headed towards closed loop –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– on the meaningful use side, does certainly raise the bar from what is common practice today in these settings.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yup, right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And maybe it's in fact place where we start to get feedback from –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

I would at least expect the feedback, Larry. I mean, I think it's an important point, but we – it's not – with just saying EMAR, which is fine, it isn't – it's defined at a level that that's not clear.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yup.

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

Just FYI, in terms of the Meaningful Use Stage 2 requirement on the EMAR, in terms of what the CCHIT and HL7 functional profile had specified in terms of criteria and functionality. Generally, there was a fairly good match in terms of the EMAR requirements in MU2 and what was in the CCHIT or HL7 functional profile, except with respect to the use of assistive technologies.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And that was really pushed in MU2, right; that's one of the big changes.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Exactly.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

It's Don, I'm not sure what the assistive technologies you're referring to are but I can imagine this generates a lot of expenses, especially when you think about the practical things of the hardware involved and Pyxis and similar things like that. So, even beyond the software, this is potentially a large physical expense item for people that may make a lot of the rest of this – we're adding just this one line item potentially is adding a ton of expense. And I think we want to be very careful about whether all of these settings actually would support that level of expense, since they're getting paid a lot, lot less than people billing under let's say hospital settings.

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

On the other hand, today's conversation has been oriented to modular certification and many of these patients take multiple medications and knowing – having technology that supports the 5 Rights is very important for many of these individuals, in terms of safety.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Oh, I agree, the medication lists on these patients is sometimes horrifically complicated and long to sort out, I mean it goes for pages and pages and pages. Still, I'm just saying, there may be other settings, for example a sort of residential psych setting where there's not that much given out in the way of meds, where this materially changes the cost of things and also may be outsourced. Because some of these med things are actually outsourced to third parties and would be sitting as a little bit of a standalone system that we'd want to think about.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

So Larry, I think in deference to time we – it is one we're going to have to define and it does – I don't know if we've ever considered defining it by setting or not, but more discussion needed.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. Thanks. Let's move on, computerized provider order entry. We're on slide 9.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yup. So what we heard from the hearing was that a subset of criteria rules such as e-prescribing, labs and other diagnostic tests and activities of daily living from the 2014 certification rule would apply to support TOC in these LTPAC settings. So this was a response in a question what criteria would support – could support TOC.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So we're looking here at meds, labs and imaging orders and again we've got the complicating factor that's often – not often, but sometimes these orders happen in an ambulatory physician system and live there and are perfectly happy to live there. Other times they live in a system controlled by the setting or by the agency, that's providing services at home. So my sense is that this is a place where optionality is usually important and that probably should be the key phrase that goes with this, is if you're adding this to your system, it ought to be something that's of value in your system and not just because hey, I can check the box. It seems like an expensive box to add if you don't need it.

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

This is Jennie, I agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And I know we're not looking to do futures now, I would suggest that a future would be, this is an area to figure out what the inner system, multisystem interoperability needs to be to make this really work well. So that a physician using their own system could write an order that was going to be carried out by a home health agency and that it gets delivered electronically to the home health agency in a way that they can actually find it useful. Its future work, if S&I Framework is listening in, they can pick it up. So with a sense of –

**M**

Yeah, I would second that, I mean I think in a world of services and remote services, we want to be able to support that and this is a future.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So order coordination, I don't know, I'm making a new term, is an area that we need future work in. Okay, let's go on to 10.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Okay, so some of the things that we heard from the hearing was defining a health IT standard for, for instance, influenza vaccine administration – oh, sorry, I'm sorry – defining a health IT standard for – yeah; influenza vaccine administration would enable information exchange between providers as well as state vaccination registries. This could reduce duplication of immunizations, for instance among different providers caring for the same person, reduce the individual's risk of receiving multiple vaccinations and provide the public health organization with reliable information and vaccine coverage within their community.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So we're looking at the ability to send immunization information using ONC specified standards, as is currently set up in MU2. So, any comments from the group about this one?

**Paul Egerman – Businessman/Software Entrepreneur**

Well this is Paul; I guess I have a couple of comments. One is I have a question about the justification that sending it to the state public health agency is going to help prevent duplication of immunizations. It seems to me that's – there's a lot of other health information exchange things that we're doing that should be helping to avoid that besides – it just seems odd that you're looking to a state public health group as that kind of a registry. And the second comment I have is I question how many of the public health groups are able to accept the immunization data on this basis? I mean all together I think this might not be as...have the utility that people are hoping for.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I think we heard specifically from some of the public health folks who said that there was high value for their knowing about coverage. In that case, it would be less about avoiding duplicate immunizations and more about knowing for a population how well we have coverage.

**Paul Egerman – Businessman/Software Entrepreneur**

Um hmm.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So it might be a more relevant comment could be brought forward for this. And some of what we heard from Stan Huff, if I remember correctly, he was using this as an example of where Intermountain had a more advanced interface with the state public health that they could retrieve information as well as supply information. And I know that's the intention of some of the public health registries is to make that information available and to create summaries of immunizations. And I don't know what the uptake is of those, I know that they're out there, I have no idea what the uptake is.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Are they doing this for adults or is that all for pediatrics, because I think there are probably very different workflows for kids who are largely in school – in the school system –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

– can have all of that infrastructure versus – and have a whole bunch of different immunizations they're getting where there's a real value to tracking it. Versus essentially what we're talking about here is flu and Pneumovax, I think are the practical matter.

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

So this is Jennie. I just wanted to, and maybe everybody recalls it but, excuse me, Dr. Stone from CDC was the person who talked about the safety benefits that could be realized through this, by the reduction of duplicate immunizations as well as other safety benefits. Oh, and, we're having a little sidebar conversation here, but immunization data is also collected in the federally required assessment instruments, at least in the nursing home setting and could be easily reused and exchanged with public health agencies.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So again, as I recall, the requirement here is vendor ability, so it is putting some load on the vendor to be able to send. We have varying levels of state and local authorities being able to accept on the public health front, it sounds like that's increasing, but it's still variable. And that the value here might be not as much on care coordination short term, but more population – tracking population health, because we don't have a requirement to get the data back, there's only send it to the state. And the statement that in fact this might be of value in this setting because they do track immunizations, and they have to report it in other context. So, maybe this is also a good place where we could keep track of, this is another crosstie to other required documentation and to the varying comments about workflow that in the implementation should respect the use of data rather than re-entry of data.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

I think this is going to be a hard one to come up with specific language that's really, truly useful.

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

Who was that?

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Don Rucker, I mean, just sort of going back to some of the challenges with pediatric immunization records, I think this is going to be a challenge.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

So Larry, I don't know if this is any help but the basic requirements say that a user needs to be able to record, change and access the immunization information, which I think goes to Jennie's comments. And then on the vendor side, that they just need to be able to create transmission files following an HL7 implementation guide for immunization messaging and convey it – the content using CVX. So, it's pretty straightforward.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

But the information you know about the immunization is really only what you've done, what's in your record, right?

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Correct.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So the care coordination piece, the not to duplicate immunizations, the current criteria doesn't fully address that.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Um hmm.

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

And the transmission requirement Sue is transmission to immunization registries.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

The wording of this is exchange with immunization registries, but as far the transmission, it doesn't give you any more content Jennie.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

I mean part of it then, you get into the issue with each year's flu vaccination is a different thing and how are you going to transmit that type of information?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, in a useful way.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Right. So and again, this ties to the MU requirement because this is a core objective for both EPs and EAs and the MU requirement says, capability to submit electronic data to immunization registries or immunization information systems, except where prohibited and in accordance with applicable law and practice. So, again, this is just in support of that core objective.

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

Yeah, so this is Jennie. I'm listening to this conversation and it sounds like it will – it sounds like other than enabling the user to record, change and access immunization information, it sounds like these other criteria need some work. But I think it's an important health and safety concept that if a criteria – a useful criteria could be articulated, it would be important in this area.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

But I'm also hearing that that's broad, the value here is not just in these care settings, the value here is broadly in healthcare. So, given that we're trying to work within the existing MU structure, this might be a great thing to bring to the other workgroup to say, we've talked about this –

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging, & Long-Term Care Policy**  
It needs a focus.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**  
– perhaps the Meaningful Use Workgroup can give it focus.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Right and give it focus understanding that the adult institutionalized patient, the immunizations they're actually getting, I think are very different than what this has historically been targeted to and what this space has discussed is a clinical matter.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Good point. Okay, I'm going to move us on to the next slide, which is actually a pair of slides looking at setting-specific things. So this is an area that's not in MU, because meaningful use doesn't address these care settings. They have mandated assessments. And so the question is really one of in some ways clarity around what's necessary in an EHR if you're in a care setting and you have mandated assessments, should your EHR support you in creating those assessments? It's important to remind folks who are used to assessments in acute settings that are usually very specific clinical assessment of a particular thing, it could be a skin assessment, could be a range of motion assessment, could be something. Whereas these are typically MDS asks us hundreds of questions, a big thick manual of how to answer the questions. They often look over a period of time, so it's not just a point in time assessment, but over the last several days, couple of weeks, how much rehab has this person gotten? How much support have they gotten in their activities of daily living? So, this is not necessarily primary documentation, this may be more synthetic or built on top of primary documentation.

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

And these assessment results are used for multiple purposes, used to construct payment rates for the provider, used to construct quality indicators and for the providers used to develop care plans and used to support associated point of care data collection related to the care plan.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, pretty complex beasts. The changes in these requirements have driven a lot of the adoption in these care settings over the years. As the assessments have gotten more robust, they have driven more robust implementations of technology. So it's an area where I think we need to be very careful what we ask for, because we have long history of a lot of top down, this is what you will do, sometimes with very good effects and sometimes not.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

This is Mike and we have the same problem in behavioral health. But my only – going back to our early discussion, if these are all going to be modular, then as a provider buying a system, if I could see that a certain system does all this and has incorporated it – this into the system. It's going to be easy for me to pare out – easier for me to pare out which systems I want to even begin to look at. So, I think it's helpful in that regard. But I agree with you, if it was part of a whole big package, I wouldn't have it as a whole big package, but as a module, I think it makes sense.

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

So this is Joan. I'm wondering are these assessment things supported now by the marketplace. In other words, I'm trying to figure out how difficult this is.

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

Yes. The long-term post-acute care vendors have developed – I would assert, most of the long-term post-acute care health IT EHR products that are out in the market support these assessment transmission creation requirements.

**Paul Egerman – Businessman/Software Entrepreneur**

So – this is Paul, I had a question similar to Joan's, because I'm reading what is written here in red and don't understand like the middle bullet, support the use of accepted vocabulary standards. I just don't understand, what does that mean, accepted, is that a specific voca – is there a specific accepted vocabulary, are there multiple, what is the current state of the art here?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So that is a – that's a problem. So today, these assessments have been built in silos and don't port well from one setting to another. There was an attempt to create spanning assessment, called CARE, which got a fair amount of testing in the early 2000s, I think if I have my timing right, mid-2000s and some elements of which have surfaced in additional requirements over the years. But these assessments often – so our earlier discussion about interoperability might apply inside an organization. This is the place where it gets most touchy is how do you reuse information you've already got in support of these assessments, without creating the kinds of problems Joe's been describing of, I'm forced to check a box. Either it's going to show up in something downstream, but it makes little relevance to me as a clinician taking this step or it's forcing me to say something that's true, but not really relevant to my thinking.

**Paul Egerman – Businessman/Software Entrepreneur**

So I'm listening to you and I'm wondering if this is perhaps not quite ready for primetime. If there's some additional standardizations that need to occur on vocabulary and transmission and receiving this, otherwise we're just going to have people who, in a different way are able to check the box and say they have the capability, but it doesn't give you anywhere near the interoperability that this is sort of suggesting would be useful.

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

Health IT vocabulary standard such as SNOMED and LOINC have been linked to the content of the nursing home minimum data set, which is one of these federally required instruments, also to the OASIS which is the federally required instrument in home health settings and also to at least one of the care assessment documents. In addition, HL7 has balloted standards for assessment instrument questionnaires and also has balloted a standard – a CCD standard for clinically relevant items extracted from these assessment instruments for – in the nursing home MDS and the home health OASIS. So there are standards available and at least with respect to the long-term post-acute care assessment summary document, are in use in various exchange activities across America.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So to maybe oversimplify my beginning, this is one I guess I'm too close to, this could be really simple. There are existing assessments that have a pretty tightly defined; this is what the user needs to be shown. They have a very tightly defined, this is what you need to produce to submit to the government and so it could be a pretty simple, focused, modular piece that says, this is the assessment required in this care setting. Does this system produce the assessment – is there a way to produce it? Is there a way to transmit it using the standards? And then all the other stuff, you're right, is not ready for primetime, because that's my desire that once ONC gets into this and sees the diversity of what's in here. That if the internal folks will start to go, oh, we get the problem of as patients move from care setting to care setting, this data doesn't move very well. The feds are asking for different things from different care settings, maybe we can collectively as a federal organization streamline what we're doing and get more focused and bring some informatics to this problem that may be hasn't been there before.

**Paul Egerman – Businessman/Software Entrepreneur**

Well –

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

So this is Jennie and I just say real quickly and clearly, I really disagree with Larry on this point.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

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

Sorry. And here's my disagreement. Yes, I agree with the first part, here's a bunch of federal requirements and yes, have some health IT requirements, certification criteria to support the federal requirements. Those federal requirements are the backbone to the health IT products being used in most of this space, including information exchange, as individuals transition across care settings, when you look at what's happening in Massachusetts and their health information exchange activities there, as well as what's going on in Tennessee and other areas in the country. They're looking to the content of these assessment instruments and what they can use or reuse from this assessment instrument support the transitions of care. And so I think if you only target the first part of this, which is the federal form, this is a huge opportunity lost, both given work that's under way at CMS to establish a data element library that's going to hopefully link the assessment content with the available vocabulary standards, and make that available to the public. And it's also a lost opportunity in terms of the rulemaking timeline that ONC is under, as well as CMS. And so coming up with a voluntary, modular certification criteria I think would help accelerate this sector, in terms of interoperable health information exchange.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

And it sounds – its Don –

**Paul Eggerman – Businessman/Software Entrepreneur**

This is Paul. I just want to make the comment that some of these questions started with Joan asking, what is like currently being done? And there's a long way from what is currently being done to hearing that there are some standards that have gone all the way to the stage of being balloted, which means people are just voting on what the content is, but they're not necessarily being used anywhere. And I just think it's difficult and possibly dangerous to try to use this new – this sort of new people are calling it voluntary certification to put forward totally new technologies and standards as modules with a hope that somehow that's going to spur development. It could have the exact opposite impact.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

I would just point out that I think this is probably the area where the customers are actually best empowered to figure out what's working. Unlike some of the other things where if I'm one of these facilities I probably don't have the informatics experience, I think customers actually can be very good in the sales process, this is the number one thing that they're going to be asking for is, how do I fill out the form using your tool, right? I mean this is the absolute central purchasing decision for these folks. I think our value add here, given that customers are focused on that, know the forms, know the data sets, is probably far less than on the other slides where the process would add some information to the customers that they don't know. Just throw that out there.

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

Except with respect to the application of the standards, I think the long-term post-acute care provider is the customer, largely – they don't get under the hood and think about these things, that's not their business, their business is care giving. And, just to be very clear, there is some implementation happening with respect to the use of these standards. For example, KeyHIE has developed a transform tool that applies these standards to these assessment instruments. Indiana we heard last week, I think it was last week, at an ONC sponsored community of practice meeting where representatives from the State of Indiana talked about their use of the KeyHIE Transform tool to support interoperable health information exchange, leveraging KeyHIE so that they can make their assessment content interoperable to support information exchange at times of transitions of care. They noted that it was very affordable and they – in a subsequent conversation following that community of practice discussion, the representative from Indiana said that they expect to extend that Transform tool interoperable health information exchange technology to more of the nursing homes in their state.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

But the Transform tool is fundamentally a work around; I mean I think we shouldn't be asking for work-arounds of federal policy that's not harmonized. I think that other parts of HHS that are putting out each of these standards, they should do that harmonization within themselves and present that to the world. That shouldn't be something that we jury-rig on ad hoc with the Transform tool because in reality, the Transform tool, no matter what of these vocabularies you use, are all going to be quite imperfect. I mean that's sort of, I think, the wrong way to sort of go about this.

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

However, while the world would be a far better place if there was uniformity in the data elements across these various CMS assessment instruments. We are not there. CMS has been looking for uniformity, as Larry mentioned at least since the mid-2000s and we are likely to be many, many years away from realizing uniformity across these assessment instruments because these data elements are integrated in CMS payments and CMS quality indicator policies. Trying to align across these complicated rules, across multiple provider settings will be at least a very long-term process. So in the meantime, here is an opportunity to support the reuse of data that's collected across 15,000 nursing homes, 9000 home health agencies, several hundred, if not more, rehab facilities, several hundred long-term care hospitals, by applying health IT, codable vocabularies to them to support the reuse of that content for exchange, for example at transitions of care.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Well, I would just throw out that I think it's too complex to change fundamentally; Transforms don't magically make one thing into something else, as a general rule. I think if it's too complicated to do at the federal policy level by the agencies who control it, I think we should be very careful of sort of thinking that even if somebody has used something on an ad hoc, jury-rigged basis in the states you mentioned, that this should be our policy to put another ad hoc layer on this, it should be fixed fundamentally, if we're writing federal policy.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

(Indiscernible)

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

Who was that please?

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Don Rucker.

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

Yeah, on the other hand, I think if you could attach a SNOMED code to a concept of ability to walk and you attached a different SNOMED code that described the person's ability to ambulate, I think being able to exchange those – that coded content would still be useful to the receiving care provider.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So this is all useful conversation to the bigger story, but what would we want to say, as advice to ONC. So I'm going to assume we can check the first box that says standard assessments, if you're doing this product and you're in this space, check the box that says you do it. And there's no guarantee to allow, there's no guarantee, you just do it. And beyond that, it seems like we're having a lot of discussion about standardizing content, about improving reuse, which are important things but are they actually relevant to what we're trying to sort out here? Not to be overly harsh, but trying to get us focused on something we can decide in the next –

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

So this is Jennie, I'll just start. Not surprisingly, I support all three of these recommendations.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, in the future – you're supporting the future work on the next slide, too?

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging, & Long-Term Care Policy**  
Oh, let me see the next slide.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Let's get them all, let's do them all. I think if we can address them all that would be great.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

So Larry, this is Michelle, can I do a quick time check and see where we're at – be able to finish?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah and so it's already 1, we're half an hour over, we've got this slide, I mean these two slides on the assessments, we have another slide on supporting the survey process, we have a final slide that asks for ONC to do some work on what's out there; surveys to get better information about what systems people are using. So that's what's left to cover. Where are people in terms of staying on longer or in terms of our technical ability to even have a longer call at this point? Have we lost everybody except Jennie and Paul Egerman?

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

Joan's here.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Oh, okay.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Don Rucker, I'm here.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Marc this is Michelle, I mean Larry, this is Michelle, so let's try and end by 1:15 for real this time, so that we can keep moving.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So Jennie, can you wrap up the high points of these thoughts, not the first one, starting with support use of accepted vocabulary, standards, ability of provider to designate a third party.

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

Yes, can you go back one slide?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sure.

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

So there's – on this particular slide, there are three recommendations –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So we're on slide 11, right?

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging, & Long-Term Care Policy**  
I'm looking at the WebEx.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Oh, I'm sorry.

**W**

Yes, it's 11.

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

So the first is to support the ability to create, maintain and transmit these assessments in accordance with CMS requirements. It seems like everybody's in agreement.

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

Yes.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Modular, yes do it.

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

Next criteria or next recommended action – I'm sorry, go back one slide please, is to support the use of the health IT vocabulary content standards to assessments for clinical and administrative purposes. A lot of discussion about this, some people thought it was not ready for primetime. I was advocating strongly that there are standards available and they in some instances are being used. So I support that one. Who either supports that or objects?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So let me ask a focusing question. This then becomes a capability in the EHR?

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

Correct, modular EHR.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

A modular EHR would have vocabulary standards not in the current assessments that have been developed otherwise –

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

Correct.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– that those mappings, that additional information would be published as an ONC standard, right? Would be incorporated as pointed to by ONC –

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

Yeah, pointed to.

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

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– pointed to by ONC as an existing standard that could then be tested against.

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

Implemented. Used.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability, Aging, & Long-Term Care Policy**  
What do you mean tested?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

The vendor would have to –

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

Oh, yes.

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

I'm sorry, yes. Sorry, yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So we're adding a piece to the thing, you're saying we have existing things, they're not new this year, they've been out there for several years, incorporate them in what gets tested.

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

Correct.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So expanding beyond what's currently in the required deliverables of these vendors.

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

Correct, as part of this module.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

As part of this module.

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

As important in the long-term post-acute care space.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

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

Correct.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

So do we have any other feedback on the phone about this, the second bullet?

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Well, I wouldn't – Don Rucker again; I would not be able to support this one. I think we're essentially writing – as a computational matter, I think we're writing what will turn out to be conflicting standards and I think from a federal policy point of view, there's already enough controversy on ICD-9 and ICD-10 and the impact of some of the CPT things. I think this will not end up in a happy place for the overall goals of what we're trying to accomplish here.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, let me try to punt to our parallel committee. So maybe this is a place where the policy should be brought and the specifics should go to the Policy Committee – to the Standards Committee and we should be saying, standards have been developed, you guys, your job is to assess are they ready for primetime. And if they are ready, then incorporate them. So this would be a specific area where there are standards in place, already defined through federal work that supplement these existing assessments. Are they sufficiently mature that they could be included in certification criteria?

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

I'd certainly agree to that.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Is that Don?

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

Yes.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Jennie, are you okay with that?

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

Yeah, I think that's fine. The only thing I was – I think one of the things, if you flip to the next slide please, I think one of the things that's important that would enable this recommendation –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

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

– if it were to go forward, is the data element library. I think that's a very important component of this, because I think, at least the way I've been thinking about it, is making publically available a data element library that links for the MDS, for the OASIS, for these other federally required assessments. The vocabulary codes and contents linked to those assessments, I think we'd certainly take us to happier place than what Don was envisioning the outcome could be. And so I'm wondering if there's any possibility of getting perhaps by the time this goes to the Standards Committee, some clarification on the timeline of that.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Does that element library – I mean, are you saying that exists right now or we're encouraging some agency, National Library of Medicine, HL7; we're encouraging some entity to create it?

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

So we heard during the public testimony, CMS talking about the importance of having such a data element library. And so I think maybe going back and getting some clarification on that might be helpful.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Right, because we're basically doing something for vendors and their customers, right? This sounds like this is a request of somebody who's not been in the space that we're discussing right, it's a request of somebody else, which sounds – to be worthwhile.

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

I missed your last sentence.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Well, this is a request not to a vendor –

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

Yeah.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

– or to a customer, right, it's not to a vendor to be certified or tested or to a customer to attest or somehow prove the use of something, this is a request to some third party to provide or make clear or identify the existence or build this element library.

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

Correct. And again, CMS, when they were speaking to this group back in December, I guess it was, maybe January, talked about the need for this. So, Larry just stepped out for a second. So I guess everybody is okay with this punt to the Standards Committee and trying to get some clarification about the creation of this data element library and the timing of that?

**Joan Ash, PhD, MLS, MS, MBA – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University**

That sounds reasonable.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

(Indiscernible)

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

Okay, so maybe go on to the next slide.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yes. Okay, so in terms of what we heard from the hearing on the survey on certification testimony, we heard that surveyors need prompt and complete access to EHRs to complete the surveys as required. That it would be interesting to consider for the EMR certification program could also include certain interoperability with the QIS process, which stands for Quality Indicator Survey and that it is imperative for the surveyors to look across modules of the EMR to understand the timelines, how the different care components fit together. Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, so, this is another area of new effort and what we've put in here as a recommendation is to in fact create some new criteria that addresses the needs of surveyors to have access to systems. I could imagine that this could be tremendously helpful to them, because they would walk into something that was a known capability. And it's going to take some effort though, to get this right. And I don't know that we've heard enough in terms of details of the process that we could be making focused recommendations here, other than a broad one that says this is a key activity in this setting. And support for the surveyors would actually be helpful, as well as to the state regulators and CMS in their efforts to provide oversight, as well as to the providers in having clarity of what's expected when someone shows up.

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

Is this another punt to the Standards Committee to get specification on?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Ummm, nah. No, I think this is less about – well, I think this is a question of functionally what's actually needed and defining of good functional requirements that doesn't overly constrain how it's done. This – no, this would be an area that I would say, this is real work for somebody that's not – a couple of hours of discussion. This is substantive work, important, but I don't – we don't have something to build on here.

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

So you're saying not ready for primetime?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I don't know any others on the phone have thoughts? Is this ready or not ready for primetime?

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

I mean, I guess I'm just wondering is a general rule-based access –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

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

– I mean, I'm trying to understand the level of complexity behind this.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. The question is if you're going to have something that's of any substance, so you could say, you need a role that is a surveyor role. You say, okay great, I'll set one up, it doesn't do anything, but I can set one up in my system. Or some other vendor sets one up that's very, very helpful, having – I guess the question is, do I put any substance in here that's useful at this time or do we wind up with a bunch of this is future, this is important to the use and adoption of these systems. We need clarity; we probably need clarity from CMS as well on what they require in the survey process.

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

Actually Karen Tritz, who's from CMS –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

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

– Office of Survey and Certification is on the telephone and so she can speak up. Karen, can you – actually, she may not have the capability right this second. Karen can you talk, can we hear you? No, so we're almost at the point of public comment, I guess, and so Karen, if you hang on just for a couple of minutes, we can hear you, please.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

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

So it just seems like this is a very important business function –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

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

– in long-term post-acute care and surveyors have been struggling with trying to get input and complete useful access to records, so, maybe we'll hear from Karen some ideas –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I also think it applies to the –

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Jennie, can – what was Karen's last name?

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

Tritz.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

It also potentially applies to the eligible hospitals for other people who are doing surveys, so Joint Commission, gets access to systems when they come and presumably the EHRs facilitate that in various ways.

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

Karen, are you on the line?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

We're just going to make sure that she's first in the public comment queue.

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

Oh, okay. Yeah, I mean perhaps one difference, Larry, and it's been a few years actually, since I've looked at budgets, but the frequency of survey and certification or accreditation really is, on average, every 12 months in nursing homes, I think a little less frequent in other provider settings. So it's a very important function.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I didn't want to minimize the importance; I wanted to suggest that in fact this is a broad topic, beyond just these providers.

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

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I think we're going to have to come back to this.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Come back. Okay. So that brings us to the last slide, do you want to –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, the last slide, oh my God, we're only one minute over Michelle's time. Additional proposals. One of the problems going into all of this is the lack of good information about what's currently implemented. The Meaningful Use Program drives a lot of reporting. There is a lot of reporting in these care settings through survey process, for example, with very standardized protocols and there's been some assessments done through various federal agencies and through various associations to try to assess the level of adoption. But the instruments being used to collect the information vary and they're often self-report and because they are self-report we don't really know what people – when they check a box, what did they check. So this is a proposal that says we'd like to get better data and we'd like ONC to figure it out.

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

I agree.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

The helpful thing here would be even if we could have a crisper understanding of what categories of institutions fall into this. I remember listening to John Derr back when we were both on the CCHIT Board and it was always challenging for me to understand how many different types of institutions would fall under this certification program. So having some clarity just on categories, let alone what they're actually doing, would be really helpful.

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

Just FYI, at the start of this workgroup's meeting, one of the documents that was sent around is the other provider study, or the link to it in your earlier slides. And the other provider study talks about providers who are not eligible for the EHR Incentive Program, like long-term post-acute care or behavioral health, and it defines those ineligible provider types and clusters them by long-term post-acute care or behavioral health or safety net providers.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Are we ready for public comment?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I think we're ready for public comment.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Okay, we're ready for public comment, Michelle.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Okay, Liz, maybe – we'll work with the group and figure out a plan for moving forward, tying up some of these loose ends. We'll send you an email with the plan. Will that work Liz?

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Sure.

**Public Comment**

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Okay. Operator, can you please open it up for public comment?

**Caitlin Collins – Project Coordinator - Altarum Institute**

If you are listening via your computer speakers please dial 1-877-705-2976 and press \*1 to be placed in the comment queue. If you are listening via your phone, please press \*1 at this time to be entered into the queue. We do have a public comment. David Tao, are you on the line?

**David Tao – Technical Advisor - ICSA Labs**

Oh yes, okay, ready. Hi, this is David Tao from ICSA Labs. Hello. Thanks for the opportunity to make a comment. During the discussion of advanced care planning, it was said by someone that an "or" in a certification criteria would mean an "and" for the vendors. I believe it really is an "or" for the vendor, not an "and." An "or" in a usage objective for providers can translate into an "and" for vendors who have to support all the providers that they might have. But an "or" in a certification criteria, I believe, really is an "or." For example, vendors getting certified for MU2 have an "or" for many vocabularies that can be used to code procedures. Any given vendor only has to code using one of those, not all of the vocabularies. So, thank you for the opportunity.

**Caitlin Collins – Project Coordinator - Altarum Institute**

And –

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you David. Sorry, go ahead Caitlin.

**Caitlin Collins – Project Coordinator, Altarum Institute**

And do we have Karen Tritz on the line for comment?

**Karen Tritz – Director, Division of Nursing Homes – Survey and Certification Group - Centers for Medicare & Medicaid Services**

Hi, yes, this is Karen Tritz. I just wanted to respond to some of the comments that were made earlier about the role of the surveyors and what the surveyors need. I'm the Director of the Division of Nursing Homes in the Survey and Certification Group. And I think – and provided the testimony to the committee a couple of weeks ago. And I think what we were thinking about in this area is that the surveyors come in unannounced, would need to be sort of as efficient as they can be in the survey process. And so to what extent can any certification requirements establish outside time frames for providing access to external surveyors who may need to access the medical record and what kinds of navigation tools could be built in, if any, to help them in their review process.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thanks for clarifying.

**Caitlin Collins – Project Coordinator, Altarum Institute**

We have no more comments at this time.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. Well I want to thank everybody; we've really gone over, appreciate that you could hang in there with us. We have an upcoming call on Friday the 24<sup>th</sup>, which will be our first steps into behavioral health. So we'll be hearing from behavioral health about how they're put together. I appreciate everybody's time and effort. We'll be doing some behind the scenes pulling together all the stuff we've heard on LTPAC and getting some materials back to workgroup members that we can finalize down the road – soon down the road. Thanks again.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you Larry.

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

Thanks everyone.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Bye.