



HIT Policy Committee Certification/Adoption Workgroup Transcript May 13, 2014

Presentation

Operator

All lines are bridged with the public.

Michelle Consolazio, MPH – Federal Advisory Committee 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. Larry Wolf?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Here.

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

Hi, Larry. Marc Probst? Carl Dvorak? Donald Rucker? Liz Johnson? George Hripcsak?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Here.

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

Hi, George. Jennie Harvell?

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

Here.

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

Hi, Jennie. Joan Ash? John Derr?

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

Here.

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

Hi, John. Joe Heyman? Marty Rice? Matt Greene? Maureen Boyle? Micky Tripathi? Mike Lardieri?

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

Here.

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

Hi, Mike. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Hi, Paul. Paul Tang? Stan Huff? Stephanie Klepacki? And from ONC do we have Liz Palena-Hall?

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

Here.

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

Hi, Liz. And Elise Anthony?

Elise Sweeney Anthony, Esq – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Here. Good morning, Michelle.

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

Good morning, Elise. Is Jennifer Frazier on as well? Okay, with that, I'll turn it back to you Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. Well, we had a very full week last week. Some of us got to be in DC together, a couple of folks were on the phone. I appreciate everybody's participation. It was a pretty full week; we're going to recap some of the things that we went over. Next slide, please. We're going to recap some of the things that happened last week, and then we have one piece of the setting-specific work that we hadn't covered when we switched to providing feedback on the 2015 NPRM, so we'll pick that up. And then we are about to publish a blog inviting people to provide us final public comment as well as to join a listening session next Thursday, a week from Thursday. So, that's the agenda. I decided that if we actually were focused, since a lot of this is recap, that we could be done, actually, I was suggesting to ONC in an hour and they convinced me that this group needs to get the full diversity of thoughts out there, so it's more likely an hour and a half. So let's see what we can do on that front. Next slide, please.

So this is a recap of the work plan from the last time we met and a couple of things to point out. We had originally planned to hold the listening session today, but because the blog didn't get out last week, and we didn't have a good way to invite people to participate in the listening session, we moved it to next week. And partly the blog got held up because it needed to get – getting the magic code number. It needed to make sure it was viewable for those with visual impairments, some addition – clean up the body of the template for response. So that's going to go out I think today, is that right Liz? Today or tomorrow?

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

Yeah, today or tomorrow.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So that's moving ahead. Then we'll have the listening session next Thursday. We've got one final wrap-up group meeting on May 28 and then we'll be presenting recommendations to the Policy Committee on June 10. And other than feedback from the Policy Committee, that really is going to be probably the last bit of work that this workgroup is being asked to do. And then ONC, as you know, is restructuring the workgroups, so the efforts that we've been working on will roll into one of the new workgroups. Let's go on to the next slide.

So, last Tuesday I presented – yeah, I presented our overall findings that we said would apply to all providers, including the ones in the care settings we've been looking at, focusing on transitions of care and privacy. And the real heart of the recommendation was alignment with the mainstream certification programs that ONC is running and not creating new and different certification criteria and standards for these care settings. And today that means alignment with Meaningful Use, but we keep hearing from ONC that there are other federal programs that want to do things similar to MU, and so we recognized that this very well might expand beyond Meaningful Use and our real thrust here is for alignment across the programs and across the care settings. And to stay current as the certification criteria changes. So that was our piece.

And then we asked some of the other workgroups to take on some efforts on our behalf and we asked the Privacy & Security Tiger Team to take a look at data segmentation. So this really started from us as a request to look at not specifically data segmentation, but more broadly the privacy requirements of behavioral health and the 42 CFR, I've got my numbers wrong – Part 2, 42 CFR Part 2 –

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

Yeah, that's right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– Code of Federal Register, Part 2, requirements specifically around redisclosure. And they looked at the HL7 data segmentation specs and at the initial implementation of those specs and had some interesting things to say. The thing that I found most interesting was it didn't require symmetry, that there's something about how the document is created under data segmentation that makes it unreadable if you don't have the ability to interpret the tags.

I think it's a very clever thing, I don't know how it's done, I haven't researched how it's done, but it was informative to me to understand that not – that the way in which the documents were protected didn't require that all providers be at the same – which I think is actually a great way to move forward. And so in fact, it might be something that would be specifically needed in settings that were doing behavioral health issues. But it was also pointed out by the Tiger Team that there are other regulations, mostly at the state level, that require additional privacy controls, additional consent for information beyond what's covered by SAMHSA. And that, in fact, these controls, the data segmentation, might be valuable for a broader set of providers.

Paul Egerman – Businessman/Software Entrepreneur

Larry, can I make a comment?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sure.

Paul Egerman – Businessman/Software Entrepreneur

So this is Paul Egerman. I agree with what you've said, but I just want to make sure I heard it right. I also heard, though, that they really weren't doing data segmentation, that basically what they were doing was it was like all or none. So if there was a substance abuse record, they weren't able to take certain data elements and view them, it was either viewable or it wasn't.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right. It was really document level.

Paul Egerman – Businessman/Software Entrepreneur

– did I understand that correctly?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

It's interesting because it's a standard about data segmentation, but it isn't being used for data segmentation, it's really being used at the record level as opposed to at a granular level.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right and I think that's actually a very important distinction.

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

Yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

The – it was pointed out that the way in which these documents are being handled was that they were not busting them apart, to Paul's point, because they couldn't maintain the tags once they came into the EHR. And so they were creating a read-only area – a read and don't incorporate area in the chart. So it was in some loose sense, data segmentation. But I agree it was not the kind of granular data segmentation that I think of when I hear someone use that term.

Paul Egerman – Businessman/Software Entrepreneur

It more – actually, in my mind, more follows the paper systems that existed at the time that the legislation was passed where you’d have substance abuse centers keep a completely separate paper medical record, separate from the patient’s medical record elsewhere in the institutions. They actually treat substance abuse almost like it was a separate organization. And so that if you gave permission, a pat – the provider might be able to look at both records, but there’s no – but they’re two separate paper records and they go back to separate medical record libraries. And that seems like an analogy, actually, of what they’re currently doing with their pilot. I don’t know if you agree with that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, no, I do. I think it’s – well, it’s just very similar.

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

Yeah, this is Mike.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead, Mike.

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

This is Mike Lardieri. So yeah, I think it’s similar, but it’s not quite the same as keeping two separate records. I mean, you’re keeping the PDF that comes across or the CCD, you’re keeping that separate. So, in the health record itself, it might be all jumbled together, but when it comes out and it’s Part 2 and goes to someone else, then it’s tagged and then that stays separate, but it’s just the CCD that’s staying separate.

Paul Egerman – Businessman/Software Entrepreneur

I didn’t see that they were ever bringing it together, Mike. So, I might have it wrong, but I thought they always kept it separate if it came from substance abuse; they never merged it in with the rest.

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

Well, no, that’s not true; it depends on your setting.

Paul Egerman – Businessman/Software Entrepreneur

So I misunderstood that, that’s fine, it’s misunderstanding.

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

Yeah. If you have an integrated setting, the substance use is in with everything else and then that makes it even more difficult, because then you have to treat everything as substance use, which is what we’re doing more and more. Many substance use providers are providing integrated primary care services as well.

Paul Egerman – Businessman/Software Entrepreneur

Again, I was talking about the pilot though; you’re saying that’s what they did in this pilot test?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, my understanding the pilot test –

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

Yeah, because there were some in the pilot that I believe they were integrated settings. I mean, I'd have to go back and look at the pilot.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think though, in terms of the technology, my understanding of the technology was the EMR software was the standard EMR software and is being in fact sold as – by that vendor, as part of their mainstream product now.

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

Yes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And that when the documents come in, they're essentially kept sep – they're kept within the same EMR, but they're still segregated.

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

Correct.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And they're flagged as special and there was some discussion in the Policy Committee about how providers would then work with those, because they lived in the document section of the record, they didn't live in the integrated data aspects of the record.

Paul Egerman – Businessman/Software Entrepreneur

Yeah. So for example, they would not be able to use, I assume, I don't know this, they may not be able to use the SAMHSA protected – the Part 2 protected data in clinical decision support –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

– the way I understood the structure.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right, that was, in fact, said explicitly.

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

Yeah, I agree with all that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And it raised the question about the patient is allowed to tell you about what's happening to them in the protected space, and if they do that without – if they do that freely, with informed consent, if you will, that information can then be incorporated fresh into the EMR.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

But there was concern about if you just handed somebody the document and said, sign over permission to incorporate this, that that was not what was intended.

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

Yeah, and that doesn't work because then once you do that, it's the redisclosure piece that gets everyone. So once you do that and it goes to the next provider, the patient actually sa – and then it goes to another provider, the patient actually has to say ahead of time, and agree to it going to that second or third provider, that's where the whole thing gets jammed up.

Paul Eggerman – Businessman/Software Entrepreneur

And so, I didn't mean to like hijack this discussion of the material, but, my understanding of the progress is it seems like there's progress on the Part 2 stuff. But they really haven't made progress on actual data segmentation in the sense of like somehow a granular level of taking some data elements or some things into the record and some things not, it's still an all or none.

Larry Wolf – Health IT Strategist – Kindred Healthcare

That's my understanding as well, Paul.

Paul Eggerman – Businessman/Software Entrepreneur

Okay.

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

And just so you know, next week, or I think it's on June 11, it just came out yesterday or the day before, SAMHSA's having an additional listening session just on this subject to get feedback of how they might tweak the reg so it could actually work more smoothly for integrated treatment and care coordination.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I think actually probably useful discussion today as well. Thank you guys. The Tiger Team is going to go off and do some additional work, it sounds like SAMHSAs doing some work as well and there's going to be a report back to the Policy Committee at the June meeting. Go on to the next slide.

We also asked the Quality Measures Workgroup to take a look at the quality measures used in LTPAC and behavioral health and they came back and said these two care settings two spaces are very different. There's a long history of structured assessment in LTPAC. There's some state level assessment requirements in behavioral health, but there isn't an overarching federal one. And so they were going to continue to do some work on what they thought the right way to approach this was.

And finally, our comments on the 2015 NPRM were provided to the Policy Committee and they decided to move ahead with the overall sense, what we were providing them. I think the phrase lean and mean got used, later there were some other comments about we want lean and friendly, but nonetheless, I think lean and mean is probably fine as the structure here for certification. And continuing this concern about balancing maturity of standards with infrastructure that could support other policy initiatives and to be careful not to run national experiments, that things really needed to be checked out, vetted. And that was a great lead-in to what we heard the next day. So let's go on to the next slide.

So at the certification hearing, it was pretty much a uniform drumbeat of that the process was overwhelming, not so much in theory as a process, but because of the timeframes and the complexity of what was being certified. And that that included things like that the criteria and the standards were immature, that the test tools themselves were going through development cycles and where mature, that the test environments weren't always stable. That the issuing of FAQs and additional guidance from CMS and ONC was helpful to clarify things, but that meant that people were in a constant restart process of, I'm doing development and now the spec has changed and I need to restart my development. Or I'm doing testing and the spec has changed and I have to retest. So, a lot of startup issues that persisted for months going into the certification process.

We also heard that the process for tuning certification and for tuning the whole context, working through rulemaking is very cumbersome and really doesn't work very well. That the goal is to align the, in this case the Meaningful Use objectives, which are pretty high level directed at providers, with the certification criteria, which are beginning to get very specific, nuts and bolts, directed at developers, to the test scripts and test tools that are very, very specific. And that all of those three have to line up and if they don't line up, it creates a mismatch in the process and things fail and you need to cycle back to why they failed. And it – if you're doing that through the NPRM process, you're talking about months if not years of publication and feedback cycle and that that wasn't seen to be very effective. And a continuing concern that certification is locking in too much how something is done rather than focusing on more macro, what are the desired outcomes.

Some of the folks were at the hearing, our next slide's going – actually, why don't we go to the next slide and then we'll talk about –

Paul Egerman – Businessman/Software Entrepreneur

But before you do the next slide, Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead.

Paul Egerman – Businessman/Software Entrepreneur

On the previous slide –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

I don't know if this is something that you're going to present to the Policy Committee at some point, but I would suggest a couple of additions that were important.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

Paul Egerman – Businessman/Software Entrepreneur

One was the statements that certification is causing usability problems.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

Paul Egerman – Businessman/Software Entrepreneur

And the other one is that ONC is dramatically underestimating the costs that it was like a universal statement on that. The EHR Association said it's an order of magnitude, EPIC said it's an order of magnitude higher, Marc Probst didn't say order of magnitude, but he said multiples. So, that, I think, is an important concern of the people who develop the stuff, and so there ought to be a bullet about that this is – ONC has dramatically underestimated the cost.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think those are two both really good points, and we heard those very loudly during the hearing. Yup, they should be reinforced in the summary. As far as I know, the material for the June hearing – the June Policy Committee hasn't even been drafted yet, so, that would be good to bring forward to Paul Tang and –

Paul Egerman – Businessman/Software Entrepreneur

And the tough part in this feedback as you go through the bullets, sometimes it's like you have the words, but you don't have the music.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, yeah.

Paul Egerman – Businessman/Software Entrepreneur

Because people are – were very unhappy. I mean sometimes even the hearings they're very diplomatic and you talk to them separately and you get the sense, there's a lot of frustration here. I mean, this is not a minor – a little bit uncomfortable, this is people are really, really unhappy.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. I think that showed up in the next – the key points. So let's move on to slide 6. Thank you. So, one thing that was I think a really clear, consistent message was, let's get all of the stakeholders in one room and focus on taking this discussion, which is really being done in a panel setting, and restructure it into a Kaizen process. So that we're really focusing on creating performance improvement out of this and finding the places where there's specific pain and what can be done short-term to address those and where they're more structural and there should be structural changes to address them. And not just to do this through the long cycle of rulemaking, but do it through a well-focused performance improvement process and that there's probably two speeds or cycles of stuff here.

There's a very immediate need around the current certification process within the current framework. And then there's a larger one that would look more broadly at how the regs get written and tested and how the test scripts get developed. And how – really looking to have a more coordinated set of regulations that are testable and leading all the way through the achievement of Meaningful Use and the attestation to Meaningful Use and the audit and support for people who are being audited. So looking very, very broadly at the process, but starting with a more focused one. And then something which has been a consistent theme in this workgroup although it got expanded a little bit in the hearing, focusing on interoperability, privacy and security and then the expansion was around quality measures.

My – what I heard in that was, by focusing on quality measures – well, by focusing on both interoperability and quality measures, a lot of the data capture issues get addressed. So instead of having certification that says you have to be able to capture X, Y, Z. If you need that information for interoperability and you need that information for quality measures, then you don't have to separately test for how that information is gathered, you just have to say, it needs to be there in order to do these things. We're going to let the vendors be flexible in how they set up their systems. We're going to let providers be flexible in the options that they have and how they configure their systems, but they need to recognize that the outputs, interoperable documents and perhaps other forms of interoperability down the road and the ability to create the quality measures. And quality measures that don't require check boxes, but quality measures that are moving towards the new eMeasures, we even heard about a couple of brand new, de novo eMeasures that are directly drawn from the clinical data in the EHR, specifically for hyper and hypoglycemia. So, beginning to make some very real progress on quality measures.

So certification should focus on these three primary areas and that those would become the pivot points. My understanding –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

It's Don –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Don Rucker, I think – I guess I had the sense almost that we may want to put in the word should focus exclusively or primarily or something. Because the way it's written it could sort of again, music and not the words kind of thing – or the words and not the music. I think that sort of understates it and I guess sort of the other part of this is, I suppose 2014 is sort of all water under the bridge, though if more people don't certify, there's going to be a national push to reopen that. But – and maybe it's on a later slide, but this should certainly impact the 2015 update, because I think if you don't give guidance on things like lean and mean, I wasn't hearing a 100% buy-in from folks that there was a shared belief in the impact on end users of these regs.

Paul Egerman – Businessman/Software Entrepreneur

(Indiscernible)

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

So I think we want to be a little bit more specific.

Paul Egerman – Businessman/Software Entrepreneur

Don, that's a good point; however, I tried to raise that point in the hearing –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Right.

Paul Egerman – Businessman/Software Entrepreneur

– but Dr. Tang said I was out of order and would not allow me to speak. But, there are basically two points here one is – the very first point is, the way this is written, it doesn't really mean that there's any change at all. Unless we say focus only on interoperability, privacy and security, we're still going to have the long laundry list because people would say, well we'll focus on it, but we're doing other things also.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Right.

Paul Egerman – Businessman/Software Entrepreneur

And so that's an issue. And the issue that you raised, that Dr. Tang said is outside of the scope is there's a 2015 certification, there's Stage 3 and basically I think what Dr. Tang is saying, he doesn't want to touch anything, he wants all of those certifications to continue. And – in which case, to me the whole hearing is useless because if we're just going to continue on for the next three years, doing what we're currently doing, we're really ignoring the feedback from these people. And it's actually, in my opinion, the whole thing's just going to be a train wreck unless we dramatically reduce scope in the 2015 and 2017 editions.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Right, well –

Joe Heyman, MD – Whittier IPA

This is Joe –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Yes. I mean, I'm offering this up as a way to sort of try to prevent it from becoming a train wreck and sort of sinking of its own weight.

Joe Heyman, MD – Whittier IPA

This is Joe Heyman. I just wanted to mention that first of all I agree that the whole idea was that it should exclusively look at interoperability, privacy, security and quality measures and should stop doing all the other stuff. Second of all, one of the things I noticed that was happening during the breaks was that without mentioning particular people, people were try – people seemed to hear what was said but tried to come back with a reason for why it wasn't true, or that there was a misunderstanding. And these are people who were listening at the hearing rather than people who were testifying, as if they just couldn't accept the message that was being delivered to them. So I think it's really important to deliver that message that focusing on all the counting and all that other stuff instead of focusing on interoperability, privacy, security and expansion of the quality measures is absurd and they really should stop doing that and just start focusing only on these particular items.

Paul Egerman – Businessman/Software Entrepreneur

And Joe, this is Paul. You have a good point. When we did the – on the last day, we ran around and did a summary and I forgot your exact words, but you actually summarized it really well, you said somehow that people were in some sort of denial mode and – perhaps were not hearing the basic message. It's an excellent point.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, I'm hearing, and I agree, that I came away with the sense that when we meant focus here, that this was, and I'm not going to say 100% exclusive, but this was really the clear primary, I don't know what percent, 80%, 90% focus. I did spend some time over the last few days wondering about things that didn't get talked about. So one of the hot topics that didn't get talked about was, or only marginally talked about, was patient engagement, which as you know, there's a lot of folks who are very active on that front and a lot of the methods being put forward for patient engagement though don't seem to be all that successful. And there were even some side comments from Jacob Reider to the group about everybody's focusing on portals, they specifically wrote the rules to not require a portal, that you could use apps or other ways to deliver information to patients. That in fact, very little of that is happening, people are focusing on portals. So, I think that there are some other things that maybe you say, well, if you had good interoperability and good quality measures, patient engagement becomes one of the ways to get good quality measures. Because if you engage patients, they'll take an interest in their health and they'll do the things that make a difference beyond just show up in your office every few months because they made an appointment, someone's paying for it.

Paul Egerman – Businessman/Software Entrepreneur

And – Larry, this is Paul. It's a good point because the way I'm looking at this discussion right now is should we add the word only, in other words, say focus only on interoperability, privacy and security. And so you're asking about some of the patient engagement stuff, so for example, one of the things that's in the – I think it's in the 2015 edition is that the EHR systems have to produce patient-specific educational material, I think it's in the patient's preferred language, I'm not sure of that last part, but patient-specific educational material. And that's something that EHR systems do not currently do and –

Joe Heyman, MD – Whittier IPA

Well, they try to do it, but they don't do it as well as other things that are available, and there's no –

Paul Egerman – Businessman/Software Entrepreneur

Right and the issue though is – my issue, that is, well is there any evidence that doing that affects patient outcomes? I mean, we’re doing a lot of stuff and why are we doing it? And so anyway, that is my issue and there’s a new transmit function in the certification – 2015 certification rule and so, that’s interesting but the other transmit function isn’t being used, why are putting in a new transmit function?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right. Yup. So that – and my – in the end, I wound up with, in a sense where I think you’re going as well, that if the goal is improved quality measures – improved quality and the quality measures actually are effective in measuring quality, the reason we want patient engagement is as a route to quality. Just like we would say, clinical decision support is a route to quality, just like we might say closed loop med administration is a route to quality. There are a lot of things that are in certification today that are in Meaningful Use today that are intended to be tools to achieve quality.

Joe Heyman, MD – Whittier IPA

And we don’t know any of them really do.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I’ll let people argue over –

Joe Heyman, MD – Whittier IPA

That was Joe.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Joe, thank you. I’ll let people argue over the studies whether or not they do. They certainly don’t universally achieve –

Paul Egerman – Businessman/Software Entrepreneur

And so you know what could very well be the case is that some of the things do improve quality in some settings and don’t in other settings.

Joe Heyman, MD – Whittier IPA

Right, which is the problem with the counting.

Paul Egerman – Businessman/Software Entrepreneur

Which is the problem with counting and the entire process, because if you focus on the outcome on the quality measures, then hopefully that causes people to do what works correctly – works right in their setting.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

It’s Don. I think one thing that sort of struck me in the process is that, and just hearing this is that sort of, and I don’t know how we would write this in as a suggestion. But, there’s an assumption here that there’s sort of a frictionless universe so that things just sort of happen. I mean the – for example, personalize just one minor, small example, personalize instructions to patients., that personalization only happens because a doctor or a nurse somehow figured out and chose realistically from some long complex menu, and typically it’s a two-stage process.

First, what' the ailment, then what are the "instruction sheets" that are given and then within them, what features. And so all of those things, those are very valuable for some patients, but for others, they're not. And all of those microscopic components are sort of, I think, assumed to just happen without any cost or time commitment in usability, in salary or anything else. I don't know how we sort of get these regs out of that frictionless universe and sort of focus not – I mean, I think we have to focus on the top level functions, like does this function have any actual evidence for it. But this sort of microscopic work, because that's sort of what I think I heard at the hearing, that was sort of the absolute ground zero of people's frustration.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, so this is Paul. I mean what you're raising here, what you call frictionless, it's a variation of the vendor's complaint that ONC is way underestimating the cost. But ONC only estimates the development costs; they don't deal with either the deployment costs or what you're talking about, sort of like the ongoing cost to implement these things, in terms of the consideration. And I did ask, I think it was Steve Posnack, about that and his statement was, well that stuff should be in the CMS Meaningful Use regulation, which in some sense is right, when you look at the Meaningful Use environment. But it seems to me, if you're asking people to decide whether or not something should be certification criteria, you ought to consider that also, because it could be easy to develop, but it could be it has high ongoing costs. I mean the cost could be physician time or administrative time but also sometimes can be fees you have to pay to somebody else to do something. And somehow that ought to be part of the consideration, in my view, of what's required – when you decide whether or not to certify something is to look at the total impact.

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

This is John Derr. I just want to make a couple of comments. One, I think I made them at the hearing and that was that when we talk about quality measurements, we're usually talking to those pertaining to Meaningful Use and I just wish that the CMS and ONC would get together because there's another set of quality measurements, and I'm talking more about workflow. And that they harmonize those and make sure that they're really just one set of quality measurements. And then I wish they would make them instead of sort of penalty quality measurements, to make them measurements that would help us to look at and assess how the systems working to provide a higher level of clinical care.

And then I also mentioned that I had just been to the Brookings thing on assessments, and we don't usually talk about assessments in this whole thing, but assessments affect workflow quite a bit. And we're now looking at maybe changing the assessments or adding a CARE Assessment to the other assessments that we have to do or hopefully just having one set of assessments and that the states are – all are different; they're trying to standardize assessments across all their agencies. And I know the state of Illinois commented they have I think it was six different state agencies and every one of those agencies has a different assessment for qualification and a different assessment for longitudinal care. Sorry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think also good points John about –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul; I'd just say those are great comments, John. I appreciate that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

This whole need to create consistency across the federal government, because they're creating silo – they've historically been creating siloed regulations that when they – the providers are no longer siloed, we have to deal with and figure out how to address a whole set of requirements. And if the goal here is integrated systems that actually improve our efficiency, we need things to be consistent so that we have consistent data definitions, consistent data formats, consistent reporting requirements.

Paul Egerman – Businessman/Software Entrepreneur

I agree, Larry. And also – this is Paul, picking up on what John said about the total number of quality measures and how they're really used for penalty. I mean it's overwhelming the amount of quality reports that exist, I wish we could get a recommendation together and ask CMS to put together a quality report death panel, to get rid of some of the ridiculous quality reports that we have to produce right now.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I love your naming. I think I'll just remember that for –

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

Yeah, and it's not only – this is John Derr again, it's not only the CMS, it's all these other, with all due respect to them, privacy groups of interest, that establish a quality measure or group of quality measures and then say we have to do that to win an award or something like that. And on the patient engagement subject, I was just doing a blood test yesterday and they asked me, who do they want me to send the information to, and I gave everyone, including my dermatologist, and the patient engagement really is their care coordination team. And so that's why we have to include the patient because we now, it comes up quite a bit about a care coordination team and the care team and the patient, of course, should be the center of that team.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I'm going to risk – so I'm hearing two things coming out of the discussion this morning. One is to not lose the music, not lose the tone of what was being said, and some of that gets lost in the slides because they don't have enough particulars in them. But others it gets lost in that whether it's only or primary or exclusive, that the focus – when people said focus, they really meant severely restrict the scope of certification. Not, oh yeah, these things are important, plus 57 other things, no, no, these things are important; they should be the things that we certify.

Joe Heyman, MD – Whittier IPA

I think severely restrict is great if you want to use that instead of only.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Joe Heyman, MD – Whittier IPA

But I do think that one or the other needs to be there, so that it's really plain that what we're talking about is getting rid of a lot of the noise, just speaking –

Paul Egerman – Businessman/Software Entrepreneur

And Larry, this is Paul. It's actually what you're saying now is consistent with your presentation to the Policy Committee about our general comments from the last meeting.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yes.

Paul Egerman – Businessman/Software Entrepreneur

All those were mainly on incremental, but we also wanted that severely restricted, to use your expression. This is a consistent theme and in some sense, the two – the day and a half of hearing and discussion, I think validated it and added emphasis on the need to do the restriction.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yup.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Its Don, I think – I mean I think there are two things. One is the restriction going forward but I think there also needs to be some sort of serious editing cutback of what’s currently there.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

And maybe that sort of just restating the things, taking out some of the numerator denominator, rolling, consolidating measures more towards an end goal. But I think the – we should recommend that the current 2014 measures and the 2015 measures and the processes around them need to be looked at again.

Paul Egerman – Businessman/Software Entrepreneur

I agree. I think that what you’re saying is very important. I’d probably say it in the opposite sequence, I’d say, the 2017 measures need to be reviewed and reduced, that there should not be any 2015 certifications at all, until that occurs and Stage 2 2014 also needs to be reduced. I mean basically providers aren’t able to attest right now. I mean it needs to be immediately, dramatically addressed. There’s an immediacy here that has to happen.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Right.

Paul Egerman – Businessman/Software Entrepreneur

It would be a huge mistake to just issue more certifications and just pile more stuff on now, which is what I’m afraid, is going to happen.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

So if we take this –

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

This is Mike.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

– bullet point and say future certification efforts should only focus on interoperability, privacy, security and quality and then explicitly make comments about 2014 and 2015? Because I think, as Edward Tufte has always pointed out in a PowerPoint sort of dulls messages by the very nature of the tool and I think at least at the bullet point level we should have some clarity about that. And to me, those are far more important things and the Kaizen might be a tool to sort of rethink what to do with 2014.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so I'm hearing actually in terms of, if you will, the policy piece, the Kaizen is an action. The policy piece is this shouldn't wait for the next round of Meaningful Use certification.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Right, because I think if you list the Kaizen first and maybe if there's sort of a little bit of denial, it's just inherent in the process of the regulation, people can focus on the Kaizen thing, which sort of will have them thinking their responsive, but sort of miss the deeper message. So I would have the deeper message and action items made very specific and up front, and then the tools and processes subordinate.

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

This is Mike Lardieri.

Paul Egerman – Businessman/Software Entrepreneur

So it seems like what you're suggesting is a couple of changes, maybe three changes. Where we say certification effort should focus on, we want to put some words to severely restrict or only focus on something. And then we also want to say, future certification efforts and then like parentheses, including the 2015 edition and 2017 edition, so that's something we want to clarify. And then we want to add a new bullet that says something about what we're going to do with the 2014 edition.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

(Indiscernible)

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

This is John Derr – this is John Derr again. Don't we want to be a little stronger and say, and maybe we can't in this regulatory world but, just say we want to stop the 2014 and the 17 until this straightened out. Because these guys, when we had the hearing were very strong about the things that we're talking about. And when we just say should look at and some of these nicer words, shouldn't we be a little stronger and just say, stop anymore certification until we've done a Kaizen or whatever and that we should just focus on these three things. It's just sometimes I don't think we're strong enough in what we – I know they're recommendations, but anyway.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, I'm fine with that and I think it's a good comment.

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

And this is Mike Lardieri, I agree with everything everybody's saying, but on the provider's side, if a provider's not going to buy something, don't they still have to comply with the other regulations and attest to meeting certain criteria that are over and above what we're recommending? And I'm okay with that, I think we just need to recognize that someplace, and I'm not sure if it's further in the PowerPoint that providers will be somewhat on their own to, and maybe there needs to be a process of identifying for providers, hey, you still need to do these five things or six things, whatever they are.

Paul Egerman – Businessman/Software Entrepreneur

Well that's – but Mike, that's –

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

And then they're on their own.

Paul Egerman – Businessman/Software Entrepreneur

But Mike, that's – so, isn't what you just said the same thing as saying that we have to reduce the scope of the 2014 edition?

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

I think it is, but I thought by regulations you couldn't. I may be wrong, so if you can, then that's – I'm fine with that.

Joe Heyman, MD – Whittier IPA

This is Joe, I just want to point out that most providers who've been attesting to Meaningful Use already have the product, they own it already, and the certification doesn't really help them because they have to hope that their product will be certified.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and the vendors – this is Paul. The vendors have already completed the 2014 edition, that reducing the scope though, you could reduce – CMS could reduce the scope of what's required to attest.

Larry Wolf – Health IT Strategist – Kindred Healthcare

(Indiscernible)

Paul Egerman – Businessman/Software Entrepreneur

I mean you have a situation...

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

(Indiscernible)

Paul Egerman – Businessman/Software Entrepreneur

– we have a situation right now where only four hospitals in the entire country have made it to Stage 2 and they only have like four or five months left to go, because they're on a September 30th year. And there are only 50 physicians who have made it to Stage 2, although they are on a calendar year. But still, people are struggling with – the providers are struggling with the magnitude of what they have to do and I think CMS could reduce the scope so that more people are able to attest. I mean, people are going to be very unhappy if they do all this work and spend this money and they come up short.

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

Okay, then I'm good with that if they can't, I was under the understanding they could and –

Paul Egerman – Businessman/Software Entrepreneur

I don't know for sure if they can, I don't know for sure that they can, but I suspect if they work harder, they can find something.

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

Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So –

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

Then I'm good with that.

Joe Heyman, MD – Whittier IPA

The other thing that –

Larry Wolf – Health IT Strategist – Kindred Healthcare

This is Larry; I'm hearing that these are really recommendations or comments in some ways out of scope for us, because they're beyond certification. But we recognize that the driver for certification is Meaningful Use and that the issues raised in certification apply to provider attestation as well as to product certification. And that this is consistent with the message we heard around certification that we heard that the Meaningful Use Program as a whole is creating similar problems.

Joe Heyman, MD – Whittier IPA

Isn't that the reason that we're recommending the Kaizen process is because we understand that it isn't just certification, it's coming from the very beginning?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well, I think – what I heard on the Kaizen piece is that they were going to focus initially on certification narrowly and then they would broaden that to include the broader connections from the definition of Meaningful Use through –

Joe Heyman, MD – Whittier IPA

There were a couple of us listeners who never even heard of Kaizen before that day and that would be including me, and I'm still not sure of what the process is, although I googled it during the hearing.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And it may become – be one of those buzz words that –

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

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– the way in which it's being used is not necessarily technically correct, but is directionally correct.

Joe Heyman, MD – Whittier IPA

Yeah, but my point during the hearing, referring back to the initial slide was, that it isn't – that it does start at the top, it starts at the very beginning of that slide, when they –

Larry Wolf – Health IT Strategist – Kindred Healthcare

It starts with MU.

Joe Heyman, MD – Whittier IPA

– right, and that you can't look at certification without looking at the process that creates the MU part.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yup.

Joe Heyman, MD – Whittier IPA

The other point I wanted to make was the all or nothing process that the AMA mentioned at the end of the hearing on the first day, was – I thought was very important, but I don't know that it falls into our bailiwick. But the idea that you can do three-quarters of the stuff but you can't get credit for it unless you get 100%.

Paul Egerman – Businessman/Software Entrepreneur

Well, Joe, this is Paul, that's what I meant by CMS should reduce the scope of Stage 2. I'm sort of in effect, I'm agreeing with what the AMA is saying.

Joe Heyman, MD – Whittier IPA

Okay.

Paul Egerman – Businessman/Software Entrepreneur

We need to make it easier for people to make it to Stage 2, this is – it's too hard.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So –

Paul Egerman – Businessman/Software Entrepreneur

That's sort of one way of looking at the feedback, it's – people are saying it's overwhelming it's too hard.

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

So this is Michelle. I just want to interrupt and make sure that we're all in scope. Just a reminder that there was a – there are a number of other people involved in the hearing, making recommendations. And so I think the charge for this group is to think about how the outcomes from the hearing will affect your LTPAC and behavioral health recommendations. But we already have the recommendations from other – there's a larger group of people that were involved in the hearing, so I just want to be careful about what will happen as part of this discussion. And so Larry, let me know if I'm wrong, but I just want to be careful about who's making recommendations on what.

Joe Heyman, MD – Whittier IPA

So this is Joe. Let me just say, we were at the hearing, Michelle, and with all due respect, I do think that even though others may be making recommendations based on what they heard at the hearing, that has to do with what they are supposed to focus on. It would be crazy for us to have sat there all day and then not discussed those overwhelming things that were mentioned during that day and not just limit it to behavioral health and long-term care.

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

Well, my point is that the Certification/Adoption Workgroup, the Implementation Workgroup and members from Meaningful Use were all part of the hearing. And so the recommendations will be coming from an aggregate of those groups. Whereas today's focus and Larry please, if I'm wrong, then please correct me, I believe the focus for today was to think about how the outcomes of the hearing will affect your future work. But if that's incorrect, then please let me know.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I was encouraging the discussion really for two reasons, one is to really provide a second round of input to Paul Tang as, and I'm assuming he will be the lead on pulling this together –

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

Yes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– on where the workgroup is and also, as we're now approaching 10 o'clock Eastern, we probably should move on to our one piece of LTPAC work that's still outstanding. And having had this discussion about focus and about alignment and about things start with Meaningful Use, maybe that's a good jumping off point for our next piece of work. And I do have some I think pretty focused notes. So, I'll go over those with, Michelle, with you after this and – getting these comments back to the leaders who were at the hearing. Okay, so let's go on to the next slide.

Okay, to Michelle's point LTPAC setting specific recommendations, let's go on to the next slide. So the piece that was open and you may remember that we had a box to the upper right in our graphics that had setting-specific needs. And that we were acknowledging that there are existing federal programs that are requiring various reporting of assessments that are driving quality measures in the LTPAC settings and that these were good examples of an opportunity for the government to align its programs and harmonize what it's doing. I think the sense of the providers in the space, and certainly what I've been seeing listening to the discussions is that they're very different – the basis on which the assessments are structured and the information exchange happens today are completely different if you look at LTPAC settings and if you look at what's happening in the acute care settings.

The focus on CDA documents, for example, with a couple of important exceptions, is almost non-existent on the assessment reporting space. And the work that's been done to date on those – on some of those, I think the next slide actually, yeah, I'll hold off on that until the next slide. So, our wanting to position this, as this is an opportunity for alignment across federal programs that there's been some work done to map these assessments to the standard vocabularies. That work was done a while ago, so things have moved on since that preliminary work was done, but it would be – could be a basis for some work and some works been done.

For example, at the KeyHIE project in Pennsylvania taking the existing formats for the MDS assessment in nursing facilities and the OASIS assessment in home health and pulling key elements out of that and converting them into the data standards and formats used by CDA. So some of that work has happened and is getting real use. I've heard of a few HIEs that have embedded those converters in their work. And further, to continue that assessments, because they are being done and they're mandated, are electronic information and they could be the basis for further interoperability, but today they're not. Today they're siloed. So I think that's the general context here. Let's go on to the next slide.

So here are some specific things that were – we pulled from our prior discussions. And these are all flagged as new, because these certification criteria don't currently exist. And you'll also see that in many ways, these are really directional statements to CMS, in terms of moving ahead with getting aligned or working with ONC to create alignment across these two programs. So the first one says, we have some existing requirements to create, maintain and transmit these assessments and we would like that put into the certification – excuse me, for these systems. And I think it would be actually a useful thing for the workgroup to talk about how the workgroup members see certifying things that today are required, what value certification might or might not add to the process.

The second one is to address vocabulary standards with the aim of encouraging reuse. And the third is to look at specifically looking at CDA documents as a form of exchange. And I would like to suggest that it's not just the sending of these documents but the receiving and incorporation of the documents that could be of real value in these care settings. It's not unheard of for individuals to go from one SNF to another SNF, the first SNF is where they get their short-term rehab, and the second SNF is where they're going to be living for the next two years. And that actually sending the MDS in a form that could be transmitted and received by the provider would be useful in and of itself. And then some future direction things encouraging better alignment for content and format and looking at the data elements that are being generated. And there's been some work on this within CMS, so these are not completely de novo suggestions.

And then finally our new little grid at the bottom of what this is. And the reason we've got provider use effort here is medium is these are things that are by and large already in place. You could even argue that perhaps it's low, except that the actual effort that creates the assessments is not low, so I think medium is probably the correct tag for this. The assessment tools themselves tend to be refreshed on five to seven to ten year cycles for major changes, although they often get annual tweaks. And finally, for development, some of this would be completely new areas, creating CDA documents where they're not currently being used and extending standards, at least in terms of their use and how they're used in products.

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

Larry, this is John.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead.

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

At this thing I attended last week before the hearing, a couple of things on here. One, as far as I can figure out, the CARE or CARE Assessment has not been stabilize, I mean, the assessment itself, it keeps changing a little bit. Plus the policy or strategy of where to use it as a replacement or something that I hope it would be doing is one assessment across all care settings has not been really finalized and approved it just keeps moving around and at times, it's caused confusion. And also I asked a question about SNOMED; especially they have harmonized things like pressure ulcers from hospitals to nursing homes –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

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

– and they're working on falls and that, and SNOMED is being used, if that's what you meant by vocabulary standards. I just – I don't know, I mean, maybe we can from our angle on this whole thing, start to get this assessment thing straightened out. Because it really is af – and I'll send you two papers. I thought Barbara Gage and this guy, Larry Atkins from Long-Term Quality Alliance wrote were very good and I'll send them to you or send them to Michelle and she can send them out. Because it gave a really good history about assessments and where they all are used, because I'm glad to see this, because as I commented earlier on, we've got to take this into account when we start to look at workflow. And cannot just have two lines of workflow going across, one on the Meaningful Use quality measures, a second one on other quality measures and a third one on assessments.

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

This is Jennie Harvell and I just wanted to support this set of recommendations and also echo at least part of John's comments. These assessment instruments, the minimum data set, the OASIS, the IRF PAI in rehab facilities and I believe also the care subset for long-term care hospitals and the hospice data item set are CMS requirements for these provider settings. At least the MDS, OASIS and IRF PAI are required to be electronically transmitted to CMS from these providers, so these assessments are in electronic format, but are not linked to or don't make use of health IT standards, whether it's content or document standards. And so to me, the crux of these recommendations, as we've heard about during the course of our hearings, would be to link accepted health IT standards to these assessments that are ubiquitous in these settings and are critical to the assessment, care planning and other components of the workflow in these settings and moving these sectors forward for interoperable health information exchange. So again, I think these are among the most important recommendations that this group has considered for long-term post-acute care.

Paul Egerman – Businessman/Software Entrepreneur

And this –

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

This is Mike.

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

This is John; just to add one little point to Jennie's excellent – there is that this is how we get paid.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul and I appreciate what people are saying, but I want to also make sure we relate this recommendation to the whole discussion we just had for an hour where we talked about –

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

– people are being overwhelmed, where people aren't considering the operational aspects of how to do these things and I'm worried that we've got something here where it says in the right hand corner, development effort is high, I don't know what that means, but I'm worried that we're layering on a lot more stuff to this LTPAC setting. And people are saying, well this is a high priority, the most important thing that we're doing, well maybe we should – if that's the case and if this is really mature and ready to go, I mean I would – if it's true the standards maturity is medium. In other words, people are already transmitting this stuff to CMS and they're already transmitting the stuff from one provider to another and we already have vocabulary in place, it's just that we're not doing it everywhere, which is what medium would mean to me. If all of that's true, then maybe we should at the same time that we look at this, look back at our other LTPAC settings and look at the recommendations and look at the total, and say well maybe there's something we should remove. Because this is – we're asking people to do a ton of work where there's no compensation for – and vendors.

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

So this is Jennie again and just wanted to say that your assessment or characterization, I guess, of if all is true, then that would equate to medium use, or medium effort, I guess. Yes, these assessments are required to be transmitted in electronic format.

Paul Egerman – Businessman/Software Entrepreneur

And they currently are being transmitted, this is currently happening?

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

Correct. And on this 90 – more than 90%, probably close to 95% of the providers in these settings have the technology in place and actually transmit electronically these assessments to CMS in response to CMS requirements. And in fact, it is also true, as I think it was Larry who mentioned, that there has been years' worth of work in linking these assessments to vocabulary standards. And in addition to using those vocabulary standards, or at least a subset of them, as well as the CCD as a document exchange standard, the KeyHIE implementation in Pennsylvania supports the transformation of the non-interoperable assessments and transforms them into interoperable assessment summary documents and then those documents are exchanged back to the designated recipient.

In addition, the Massachusetts IMPACT Program, one of the ONC Challenge Grantees, is piloting the exchange of information across a variety of settings of care including these long-term post-acute care settings and they will be – I think their pilot was supposed to have begun earlier this year, but I actually think it hasn't yet started. And so I think it's any day now or maybe next month –

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

Supposed start in April.

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

Okay. So anyway, they will be leveraging the assess – the electronic assessment content created by these long-term post-acute care providers and linking them with the health IT standards, and they may be using the KeyHIE Transform Tool to support part of that information exchange. This assessment content is such a fundamental part of the workflow in these settings, applying health IT standards to the content will enable the appropriate reuse of some of the assessment content, not all of it, in my opinion useful for information exchange purposes, but a lot of it is. And so I think it's really important.

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

So this is John, again, just for background. I just want to say a word for the providers, I mean the vendors right now, the bulk of the major ones in this LTPAC setting, also the – all these assessments are very important in their EMRs. And most of them now, as they go into more clinical and support, because they do longitudinal care, the assessment is a byproduct of even a more robust EMR that they have out there electronically. That's why I get so excited when people say we have no IT systems out there when we really, as Jennie said, 95%, because this is how we get paid, have always been electronic.

And I think I've been saying that when we do an assessment out there, we really do a full assessment of the patient, which I don't think is done in any other setting. I mean the MDS, I think, is 36 pages long and the CARE Assessment's even more. And I think one of the things that we should watch out for, and this is why I think we should have a Kaizen if you will for our sector with the vendors included, because at the meeting I was at, it sounded to me like CMS was trying to do a whole EMR to sort of morph the assessments into a complete EMR when the vendors are already doing that. And I think as we said at the hearing in the acute care sector and all that, we've got to work closer with the vendors in what they're doing and not have the CMS and regulatory going one direction and the vendors go in another direction just because we think vendors aren't part of the care team.

Joe Heyman, MD – Whittier IPA

So John –

Paul Egerman – Businessman/Software Entrepreneur

Let me just –

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

This is Mike, I –

Joe Heyman, MD – Whittier IPA

This is Joe, could I just ask if everybody is doing it already, why do we need to certify it, "A." And "B," isn't the most important thing being able to transmit it as a CDA?

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

Right.

Joe Heyman, MD – Whittier IPA

And "C," I hope nobody's expecting to send a doctor 37 pages of an assessment, because that will just drive them nuts.

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

Yeah, but that goes back and forth with long-term care all the time. This is Mike, my comment is, we identified these things before we had this feedback from last week and then with the discussion we just had for the hour is about just looking at certifying interoperability, privacy and security and the quality measures. I agree that all this stuff is needed, but I don't see it as certifying to that, I see it as making sure that all of this in the first bullet "new" goes under the CDA, and all that stuff needs to be captured.

Joe Heyman, MD – Whittier IPA

My point exactly, Mike.

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

The workflow issues – yeah, the workflow issues, that gets to be to the vendor and if a vendor has a good workflow or a bad workflow, people buy it or not buy it, so, because that happens in behavioral health, too. But I think all of that is very important, but we need to make sure that all those data elements are captured and available in the CDA and that the CDA can be sent and received across the board, no matter who it goes to. And if it's coming from this setting, then we need to make sure it's, under the third bullet, and it can go back and forth.

Larry Wolf – Health IT Strategist – Kindred Healthcare

This is Larry let me –

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

This is John and I don't want anyone to think – I agree, it has to be interoperability and security and then Joe, I think the two things, and you and I were the ones that didn't know what Kaizen meant, but it was that we need to be part of the team. If we don't have some certification, just interoperability to do what Mike said, then nobody will trust what data we send to people.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

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

And then also, we're sort of sitting on the outside fence here and without just a minimum certification, we're not part of the whole team.

Joe Heyman, MD – Whittier IPA

No, no, John, and I'm not arguing about that. I definitely agree with you that the third bullet is the important thing on this slide. The point I was making was that the first two bullets are really unnecessary because of the third bullet –

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

And then –

Joe Heyman, MD – Whittier IPA

– and that I think we ought to minimize what we're doing. I agree.

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

Paul Egerman – Businessman/Software Entrepreneur

Yeah and this is –

Joe Heyman, MD – Whittier IPA

You should be part of the team and you should be certified.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul –

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

And this is Mike. In behavioral health, we're the same, so we need to make sure that the extra data elements that we need, and they're not – we're not the same level you are with these very structured assessments that you're doing in long-term post-acute care. There are some, but we need to make sure that all the stuff that we feel is important or need to do care for behavioral health is all available, able to be sent and received in the CDA as well. We're going to be in the same place as you are.

Paul Egerman – Businessman/Software Entrepreneur

This is –

Larry Wolf – Health IT Strategist – Kindred Healthcare

So let – this is Larry, let me jump in with trying to focus a piece that I think I'm hearing as a consistent theme here. So, the gap that exists today with these various assessments is they're not CDA documents.

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

No.

Larry Wolf – Health IT Strategist – Kindred Healthcare

They are structured, they are electronic, they have code sets, but they're not using – they're not CDA documents and many of the code sets they're using are unique to the assessment tool itself. And the work that's been done with the KeyHIE tool, for example, is to create a mapping from those data sets to the more widely used data sets that are part of Consolidated CDA. And so I'm hearing, in part, an emphasis that if we can get CDA documents as the form of exchange, and that's an if, then it addresses the interoperability in a very straightforward way that simplifies a lot of the go forward issues. Because then providers whose systems can accept CDA documents, would be able to accept these assessments. And, what they then do with them, to Joe's point of yeah, if they become overwhelming to the recipient, then they're not going to be useful. But if they are sent to a system that recognizes the code sets and can do something smart with them, then they could be very helpful for carrying forward specific data elements.

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

But Larry, this is Jennie and I agree that the CDA document piece is an important component of this. However, to me the difference between the second item, the second new item and the third new item on this screen is the second item here calls out the importance of applying the accepted vocabulary standards to this assessment content. As probably everybody on this call knows, there are a variety of CDA documents; this particular slide calls out one of them, the Long-Term Post-Acute Care Assessment Summary CDA document, which is a CCD. It is not the only CDA document and I think the benefit of linking the assessment content to accepted vocabulary standards is that it would enable the reuse of a lot of the different assessment content for different document types. For example, care plans, for example, CCD documents, so I think the second item here talks about applying accepted vocabulary standards and the third item talks about advancing the long-term post-acute care assessment friendly document, which is a very important transition of care document type.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

This is Don, do we have – when I hear – I always am a little concerned when I hear things like accepted standards, because I think there's accepted by a committee standards and then there is accepted in use standards, because some of these standards require extraordinary bodies of work by the providers to enter the data in structured format. I mean, sort of, if you want to take – build order out of entropy, those – you have to put – it's physics, you have to put energy into the system. And in many cases, they're, in the real world, not accepted while they may be in a sort of Standards Committee world. So it may be helpful for us if we actually had some data from CMS on what percentage of these documents that are required are coming in in what forms of structured data. And the operating test might be, what CMS actually reprocesses the data, so if CMS is actually getting all of this data in these structured formats, presumably it's not just simply going to waste.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

So we would be able to see, from CMS, some kind of publically available analysis where they use structured fields, if this is true. I mean...

Larry Wolf – Health IT Strategist – Kindred Healthcare

So Don –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

– I'm just sitting here looking –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Don, not to cut short your comments, but these documents are very highly structured.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And to the other discussions, they are very expensive for organizations to complete, because they do require very detailed completion of a form with a very fat manual of how you answer the questions. And they have – this process has been in place for probably two decades.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So yes, there's a huge investment being made by the LTPAC providers to do these assessments to get them right and transmit them to the federal and state governments.

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

There's also, Larry, there's also one nurse usually that is an MDS coordinator in a nursing home that – so there's one staff person dedicated.

Paul Egerman – Businessman/Software Entrepreneur

And so – this is Paul –

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

This is Mike –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, I don't – I still don't understand where – with Joe's suggestion. To me, if you can piggyback this on the CDA, I mean, we already have a transition of care thing, that seems like that's a good solution and it's a solution that's sort of like consistent with a lot of other things. And I suppose at some point, if you want to work on the vocabulary standards, we can do something in like an implementation guide of a future release of the CDA that tells you what vocabularies you're supposed to be using for this.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well I think –

Paul Egerman – Businessman/Software Entrepreneur

Because that seems like a better solution than to try to create something new just for these assessments as the transition of care is something we've already approved as part of the LTPAC process.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, I'm hearing in the theme of focus, that if we focus this on interoperability in the CDA, and then some of these other things become, if you will, supporting sub-bullets to that, right, that these are assessments that are currently in use. They are currently structured. There's been some preliminary work to move them to standards. There's been some initial operational activity that's doing that today. And I think to Jennie's point, the one about the vocabulary standards, what I'm hearing from ONC and even some of the CMS folks is, there's 20 years of heritage in the existing data sets and the existing workflow and the existing analytics and moving off of that is not trivial.

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

Um hmm.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And so I think recognizing that in some form and still providing direction that says, if our goal is interoperability, that's effort that we ought to take on. And I'm not saying take it on in a crash course for 2015, I'm saying – taken on.

Paul Egerman – Businessman/Software Entrepreneur

And Larry, my comment – this is Paul, my comment on that is that's an area where ONC can add a lot of value by determining, like here's the direction we want the country to go, in terms of vocabulary or data standards. It doesn't require –

Joe Heyman, MD – Whittier IPA

Certification.

Paul Egerman – Businessman/Software Entrepreneur

– certification of software, it can simply be, although it could be part of the certification NPRM, saying this is the direction we want to go.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yup.

Paul Egerman – Businessman/Software Entrepreneur

This is what everybody needs to start doing. That by itself is important.

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

And this is Mike, and I guess this is a question for Jennie and John. So if you drop this stuff down and each one of these assessments was its own type of CDA document, because there are multiple, like you said, there are multiple CDA documents, does that work or is there something that doesn't make that work?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, and I'm wondering if we're micromanaging it by making that suggestion as well.

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

Yeah, okay. Just trying to –

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

...point –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, I understand you're trying to –

Joe Heyman, MD – Whittier IPA

– important thing is to be able to send and receive it.

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

This is John, like I said – the first thing I said was, there is no, as far as I know and Jennie might comment, they're working on where CARE fits, whether it's a single assessment across the spectrum of care or whether it is a part of all the other assessments. And one of the conclusions in this thing I was at on Tuesday last week was that the states – there was a scaled down CARE assessment that came out to be one page, of course there was a lot on that one page, that the states should start using to harmonize their assessments across all the different agencies, in the Medicaid realm. And I know we're mostly in Medicare, not Medicaid, but that was one of their conclusions.

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

This is Jennie. At the risk of prolonging this discussion, Mike, in response to your question, I don't think making it a CDA assessment type document resolves the concerns that I have. I think what's needed here is standardized assessment content and then the ability to reuse that assessment content in different standardized document types. And this slide, perhaps appropriately, points to one particular document type, the Long-Term Post-Acute Care Assessment Summary as one standardized document type that can be and is, in some instances, being usefully exchanged to support transitions of care. But I want to just say that that's not the only document type that could be – could make use of – reuse of assessment content or different documents.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well I think Jennie the whole point on reuse is that we don't want to bound the reuse, right, we want to get this in standard vocabulary so it's available for all kinds of reuse.

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

Correct. And thus the importance of that second recommendation on this slide.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I wonder though, in some of the discussions we've had both within the workgroup and at Policy Committee, about if we're parsimonious in how we define things, then we can require alignment without having to necessarily specifically test for alignment at every point. So by identifying certain document types and their requirements for vocabulary, we could pick up secondarily, standardizing the data and having it available for reuse. But I – so I guess I wonder, Jennie is that sufficient or do you feel like the reuse aspect is really a primary message that you're trying to communicate here?

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

To me there are two messages on this slide that are important. One is the reuse message, which I think is the second bullet. And the second message that I think this slide is trying to communicate is highlighting the imp – one instance – one important instance of the reuse, which is this Long-Term Post-Acute Care Assessment Summary document as a basic easy, relatively speaking, easy way to support transitions of care, to and from this sector.

Joe Heyman, MD – Whittier IPA

Larry, this is Joe.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead Joe.

Joe Heyman, MD – Whittier IPA

On this slide, I don't see the word certification anywhere; I see support, support and support.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Joe Heyman, MD – Whittier IPA

I think my concern is about what we're requesting to be certified, not what we support. So –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Oh, I think Joe, that consistent with the way we framed the other slides, they were all certification criteria to support.

Joe Heyman, MD – Whittier IPA

Well, this – if that’s the case, then I would make the argument once again that we support the ability to send and receive C-CDA documents that contain whatever is necessary for long-term care and that we may mention that it’s important to use accepted vocabulary standards, it’s important to have the ability to create, maintain and transmit. But that the most important thing is to be able to have a document that can be sent and received, exported and imported. And it seems to me that all the rest of that stu – because otherwise we’re asking for an awful lot out of a certification vendor and I think that we’ve heard that that’s just not doable.

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

And –

Joe Heyman, MD – Whittier IPA

Especially when most of it is being done already.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Let me pick up on the last point and risk really blowing up our time overrun here. So, we didn’t hear this in our hearings because we weren’t talking to these providers, but I believe this applies not just to the post-acute care providers, but all providers, that CMS routinely issues annual updates to payment rules. And those payment rules include reporting requirements and those reporting requirements don’t have a certification component and also have a very short timeline, measured in weeks or months, not years. And would certification – would a certification requirement in the CMS process actually bring some sanity to this and say, as we’re moving from manual systems that require training, to automated systems that require technology and work process as well as training. That it makes sense to require a certification and testing cycle that would make the regulations have more time around them to go from here’s the reg to here are the tools to use to here’s something you can implement and bring up in your care setting to now you’re ready to use it as part of delivering care and getting paid.

Paul Egerman – Businessman/Software Entrepreneur

So –

Larry Wolf – Health IT Strategist – Kindred Healthcare

So it stops being a couple of month cycle and becomes a couple of year’s cycle.

Paul Egerman – Businessman/Software Entrepreneur

So Larry, this is Paul. I mean, one suggestion I might make is that you separate out the two different, at least two different thoughts, what’s required to be submitted electronically to CMS –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Paul Egerman – Businessman/Software Entrepreneur

– versus this interoperability concept of transitions of care and what happens when a patient’s moved from one organization or from one setting to another.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Paul Egerman – Businessman/Software Entrepreneur

And if you do that, because it seems to me that CMS transmission thing is already occurring –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Paul Egerman – Businessman/Software Entrepreneur

– and maybe doesn’t need certification, although you say there are some problems with how that all works.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

I would say one of the things that came in the testimony last week was this QRDA I think it’s roman numeral III, where there’s certification for transmitting quality data to CMS, but CMS, unfortunately is not receiving it. So that created some amount of concern, because people did a lot of work that was not useful.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

And so I’m a little worried about certifying the piece that gets transmitted to CMS, because I think CMS is just on its own clock in terms in how it makes changes. And I don’t think you need certification for that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

The information exchange is where you need the certification, because as Joe says, you need a –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Because it’s –

Paul Egerman – Businessman/Software Entrepreneur

– send and receive and that’s the place where I think we could make the most contribution. But I still think the best way to do it is through the existing stuff, through the CDA. I don’t think you want to have two different transitions of care document, one that’s used by everybody else and one that’s used by LTPAC. And you certainly don’t want to have a situation where you have to transmit both every time you move a patient. I think focus on the CDA for the interoperability piece and I would suggest staying away from the CMS transmission function, especially since 90% people are already doing it somehow.

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

This is Michelle, we’re already five minutes over, we need to go to public comment and wrap this up.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. So, I will wrap this up into some slides and get them back out to the group. And we have a public hearing a week from Thursday, so we’ll be getting broad input across LTPAC and behavioral health, hopefully. And then we’ll have a couple of weeks to wrap that up before the June 10 Policy Committee meeting. So thanks everybody for the discussion today. Thank you to Michelle for being our timekeeper. Would you take us to public comment?

Public Comment

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

Thanks, Larry. Operator, can you please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute

If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment please press *1 at this time. We do not have any comment at this time.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well I’d like to thank the workgroup, very active, engaged discussion today. I think some great things to bring to Paul Tang about our thoughts on what we heard last week and how to move them forward. Also some really good discussion about the LTPAC specific recommendations. And look forward to our continued discussion next week and thanks again for your time.

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

Thank you.

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

Thanks. Bye.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation – Ohio State University Wexner Medical Center

Bye.

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

Bye.

Joe Heyman, MD – Whittier IPA
Bye.