

**HIT Policy Committee  
Certification & Adoption Workgroup  
Transcript  
November 18, 2013**

**Presentation**

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

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

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Here.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

Mike Lardieri? Joan Ash?

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

I'm here.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

John Derr?

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

Here.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

Carl Dvorak? Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Here.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

Joe Heyman?

**Joe Heyman, MD – Whittier IPA**

Here.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

George Hripcsak?

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

Here.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

Stan Huff? Liz Johnson? Donald Rucker? Paul Tang? Micky Tripathi? Maureen Boyle? Jennie Harvell?

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

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

And are there any ONC staff members on the line?

**Elizabeth Palena-Hall – Office of the National Coordinator**

This is Liz Palena-Hall.

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

Elise Anthony.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

Hi Liz. Hi Elise. And with that I'll turn it back to you Larry.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, well I'd like to welcome folks back to this call, I think we've got a slide deck that represents a step forward and hopefully that we've heard what was said by the Workgroup members over the last couple of weeks. I would also like to take a few minutes to introduce some of our new members not all of whom could make the call yet, but who will be joining us in the future.

So, Michael Lardieri is going to be joining as a member of the workgroup and he represents behavioral health. He is a member of the National Council for Community Behavioral Health and has many, many years of experience in various inpatient and outpatient settings and particularly focused on behavioral health issues. So, I think he'll be a really good addition given that our focus for a big chunk of what we'll be doing will be behavioral health.

I would also like to welcome Jennie Harvell, and I heard that Jennie was on the call. Jennie works for the Office of National, I'm sorry the Office of the Assistant Secretary for Planning and Evaluation often abbreviated as ASPE where she's been focused on Health IT, electronic health records, Health IT standards and health information exchange on behalf of person's receiving long-term post-acute care services. She has been a long-standing advocate within ASPE for the LTPAC community and it will be great to have her on the call. And in fact she has sort of the honor of being one of our very few public commenters earlier in this cycle. So, welcome Jennie and I heard that you are on.

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

Thanks Larry.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Also Maureen Boyle will be joining us and she has been a team lead for Health IT at Substance Abuse and Mental Health Services Administration also known as SAMHSA and she has been promoting the adoption of Health IT among behavioral health providers for a while within the behavioral health community. So, two HHS representatives joining, I guess more in an ex-officio way to help us better understand what else is happening among the federal agencies related to LTPAC and behavioral health and to keep that communication going.

So, I think that's about what I've got for some opening comments. Why don't we dive into our slides? Can we have the next slide please? Okay, so our agenda today is to wrap up this step one of the charge and we've put together a five factor framework. I saw the slides earlier this morning and you'll notice it was a four factor framework and we have added one more, so there is a sense of a little bit of fluidity around this but I think it's actually pretty good given the discussion we've already had.

So, we'll review the factors that have been identified and consider using these as a framework and then we'll have the opportunity over the next several weeks to test this framework as we look at specifically behavioral health and long-term post-acute care as two areas where ONC is looking at certification programs that, if you will, are – well they're for providers outside of the Meaningful Use Program, but we have a lot to learn from what's been done with Meaningful Use.

And then after that, so sort of looking beyond our main work for today we'll be moving into step two of this charge which is looking specifically at long-term post-acute care and that meeting picks up on December 2<sup>nd</sup> and then after that we'll be having a series of meetings about behavioral health and those will pick up in the new year. So, that's the plan for today. We've got an hour and a half and we'll have time at the end for public comment.

So, let's go onto the next slide. Okay, so here we've got five factors for certification programs and this is really, if you will, looking to create a series of gates to basically answer the question, is a certification program something that should be brought forward and what are the important things to consider in doing that? So, this should look familiar to folks, these are bits and pieces from our prior discussion, it begins with health improvement need, looking to do a better job of working with federal and state initiatives, requirements as it relates to certification, looking at what's in the pipeline for certification, considering stakeholder support and then something that we've added that feels like it's really a summation area, if you will, of cost benefit.

So, of all of the approaches that might be taken to meet the health improvement need how does certification stack up and what do we see as the cost and benefits of having a certification. So, let's go onto the next slide.

**Joe Heyman, MD – Whittier IPA**

Larry, this is Joe.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah?

**Joe Heyman, MD – Whittier IPA**

There should be something about unintended consequences. I mean everything there is a positive.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Well, I think cost benefit is really intended to pick up unintended consequences so that would be some of the costs, but we can be explicit about that.

**Joe Heyman, MD – Whittier IPA**

No that's okay as long as we're not going to overlook it, because I still think it's very important and I think there are a lot of them.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And I actually think as we go through each of the factors that in fact each of them might – that might be part of what should be considered just like in many ways the cost and benefits are going to be spread across these initial four factors.

**Joe Heyman, MD – Whittier IPA**

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

And Larry, this is Paul, how do you want us to do this? Do you want to go to the whole thing and then ask questions or do you want us to be asking questions as you go through each factor?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Let's do – so the setup is that there is set of overview slides and then we'll go into each of the factors, so as we discuss each factor I think that would be the right time to discuss.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, so these are the overview slides right now?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Thanks for asking about where we are in our own flow for today. So, taking a slightly deeper look at the five as a set we have identification of a well-defined health improvement need. So, basically why should there be a certification program, what is driving that need?

And then one of the gates is are there potential improvements to existing federal and state programs that a new certification program would address and so I think to some of the concerns that have been raised about what is the upside and downside of having a new certification, we're looking to explore that here.

So, this would be, you know, under this gate, if you will, so to pass this gate is to be saying, well, is a certification program going to be an improvement or not, right? There could be perfectly adequate existing programs that are meeting this need and this would be a place to identify that.

Similarly, to say, you know, there are similar programs but they're not coordinated, they're not exactly the same in what they require or the software, so maybe this is an opportunity to say we should bring those programs together so even though there would be costs of making changes to each program in net we would wind up with something better.

And then looking at pipeline considerations. So, where are we in terms of the development of standards, of their functionality, are we in fact, if you will, incorporating something that's already up and running in the marketplace and should be minimal disruption or none or are we actually pushing the envelope of what's already available? And we're in fact going to be looking for new standards to be put in place in order to have a certification program. Moving onto the next slide.

Where are we with stakeholder support? So, is this an area that we're hearing a lot from the various constituencies that this would be an important thing to move forward on or in fact that there isn't stakeholder support and that we should be backing off on this as a certification program because the folks were hoping to help with it are saying it's not going to be helpful or is there something else that they would see as more helpful coming from ONC or the federal government more broadly.

And then finally to look to bring all of those factors back together and look at both of the options available is really certification the best one to meet the health improvement need and overall what do we see as the cost both the financial cost, it could be opportunity cost, it could be focus and effort costs as well as the benefits of moving ahead with a certification and again the benefits might be economic or they might be process benefits, they might be operating benefits.

So, before we move on in terms of the five factors does this feel like a reasonable mix of things for us to be considering?

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

Larry, this is Joan, just a point of clarification, I thought we were talking about a voluntary program here and so this is sounding a little more controlling than that. Am I mistaken?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I think that's a good point that I think I want to be clear on. So, initially we had kind of voluntary plastered all over this and it was pointed out that the existing program is voluntary as well, it's tied to incentives and disincentives so people might see it as not truly voluntary because if they don't follow it it's going to have economic consequences or it might have economic consequences. And so I think the sense was more if ONC is going to have a certification program what should be criteria of having that program in place. Am I helping address the voluntariness or not?

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

I completely understand, so just another point of clarification is that we are talking about possible incentives?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, incentives would have to come from somewhere else, right? We're being asked to say, if there is a need, right? So, the need could be because there is an incentive program, the need could be because there are other requirements for people to do something and it's felt that certification would help with that something.

So, there is a fair amount of mandated reporting to the federal government not everything has a certification for the technology to be used to do the reporting with. Is that a good thing or a bad thing that it doesn't have a certification program? That would be the kind of thing that would be explored.

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

Larry, this John, I think at one point we said the word guidance was a good word to use as well.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah. So, I think that that's – you know, John, I think if we pick up on that if you will if the government identifies standards as part of a program and then maybe has, you know, so that could be seen as being a requirement but there might be, if you will, guidance or testing frameworks or other ways to help organizations, both providers and software vendors know that in fact they are in support of that standard or that they can deliver the capabilities being asked for.

So, I think the thought is really to wind up with – we're going to be offering guidance, if you will, to ONC about certification programs but if they put one into place presumably it would have the kind of test structure that the Meaningful Use Certification Program has. And there might be value in that test structure in terms of providing support, direction and, if you will, guidance as well to people in many instances. I'm going to take the pause as a good reason to move onto the next slide, let's go to the next slide.

So, identification of a well-defined health improvement need, so, if you will, this is the kickoff reason for doing this and in our earlier discussions we identified information exchange with all providers as in fact a key need and possibly one of the many benefits of the existing certification program. So, any comments from the workgroup about both information exchange, present need or other aspects where we think that there might be some defined needs?

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah, this is Paul; I have a couple of comments on that. When I first looked at this I sort of like raised my eyebrows because I don't think that software or certification by itself really improves anybody's health, you know, I mean, basically the way I look at it is these EHR systems, these software systems can facilitate change and can help people make decisions but they're not the change, right?

In other words they can help the clinician make a decision but they're not the decision generally, I know there are a few tiny exceptions. So, I was a little surprised by this as a factor, although your examples are good examples though.

I mean, I like the idea of information, you know, doing – you know, facilitating information exchange, facilitated – improving EHR adoption, but I'm not sure I call that a health improvement need, you know, I just think the title troubles me a bit, you know, because it does get to the whole argument about do these computers really accomplish anything.

I mean, I would call this – I might reframe this thing by simply saying, you know, does the – basically does it assist with EHR adoption or does it assist with the HITECH goals that are established, you know, the goals of like quality, information exchange or reducing disparities, but it would seem to me that would be the way to deal with this is sort of this broad statement about health improvement.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I guess what I'm hearing you say is that in our examples while they're worthwhile examples that the need actually might be more around care coordination for example or –

**Paul Egerman – Businessman/Software Entrepreneur**

Or either care coordination or it could be specifically around the goals that are established in HITECH, you know, which I should be able to state off the top of my head but I can't.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

Again, information –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

But there is – right, so there are some national priorities that have been identified that –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

IOM has put forward, HHS has endorsed and to say these are the things that are a priority and so establishing a clear linkage to those priorities.

**Paul Egerman – Businessman/Software Entrepreneur**

Either a linkage to the priorities, a linkage to the ONC strategy –

**Joe Heyman, MD – Whittier IPA**

Or how about the triple aim?

**Paul Egerman – Businessman/Software Entrepreneur**

I'm sorry, I didn't understand what you said Joe?

**Joe Heyman, MD – Whittier IPA**

How about the triple aim? You know, improving the health of the population, improving individual health quality and improving cost? I don't have them exactly right, but that's pretty much what they mean.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, well again, there are a few other things though, because every time you say that somebody will say, well what about healthcare disparities, but you say improving, I would actually use the word facilitating because, you know, I don't think that a computer system by itself improves the healthcare of a population, but it could facilitate somebody doing that by giving the information that you might need to make a decision.

**Joe Heyman, MD – Whittier IPA**

Right it's a tool.

**Paul Egerman – Businessman/Software Entrepreneur**

Well that's the part – thank you for saying that Joe, that's the part that's kind of missing, these things are tools, they're not the solution.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, those are all good points that we should be clear about. In fact certification itself is intended to be a tool.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and also, as I said, the closer you could link it to in my – I'm more comfortable the closer you link it to the EHR adoption and what ONC is doing as opposed to this much broader thing improving health care. I don't know maybe other people view it differently.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so you're actually suggesting it might be tied in specifically to programs ONC has in place and ONC priorities as well as more broadly and that in fact a tighter focus might be a better one.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, yeah, I mean, otherwise I may look at this and I'm thinking to myself, well gee are we could be talking about certification for retail pharmacies or commercial laboratories, for, you know, a whole series anything and I'm not sure that we should be that broad in our scope.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I think part of the reason that ONC has asked us to look at this and has given us, if you will, a broad charge, is that they do see that they have a broader charge than just HITECH, but I think this discussion points out the desire around focusing any kind of initiative, if you will, you know, we talked about minimum necessary and other context and there is some sense of minimum necessary here as well for any government program, it should really be the most focused it can be to achieve specific goals that hopefully have broad results, but have a narrow focus and a narrow burden.

**Joe Heyman, MD – Whittier IPA**

I guess, this is Joe, I guess my slight concern about narrowing it down to the ONC's needs is that after all the ONC is overseeing the Meaningful Use Program and that's one of their needs and I wouldn't want the Meaningful Use Program to be a health improvement need.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay and again it's intended to address health improvement needs but itself is –

**Joe Heyman, MD – Whittier IPA**

Exactly, I mean, it's also a tool, it's a tool modifying another tool.

**Paul Egerman – Businessman/Software Entrepreneur**

Hey, Joe you and I are in agreement that it's a tool, again, if I think about health improvement needs, you know, I still think about, like obesity as a huge, you know, health care problem that we have in this country. I don't think we need to start thinking in broad terms about certification and do something about necessarily obesity.

**Joe Heyman, MD – Whittier IPA**

Right, I think the technology –

**Paul Egerman – Businessman/Software Entrepreneur**

I think we need to narrow things down a little bit then we have a much greater –

**Joe Heyman, MD – Whittier IPA**

The technology will though.

**Paul Egerman – Businessman/Software Entrepreneur**

Chance to succeed. Pardon me?

**Joe Heyman, MD – Whittier IPA**

The technology tool actually can help, there are ways in which it could help but what I would worry about would be if somebody would suddenly certify that it had to do it in one particular way because I think then what happens is everybody who would be innovating would suddenly be concentrated only on that issue and we lose progress and usability because everybody is trying to fix it to comply with some certification requirement.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay.

**Joe Heyman, MD – Whittier IPA**

I don't know what else there is to say maybe you guys can think about it off line and figure out a better title.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I guess –

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

Hi Larry?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

What I'm hearing is –

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

Oh, sorry, Larry, this is Elise, I just want to – I know that we're trying to finish this out today so I just wanted to make sure we have an understanding of what we think this should be, so, hearing what you guys said would it be fair to say something like is there an overarching health improvement need that certification would facilitate or maybe changing the word need to priority. I just want to make sure that we kind of close the loop on that so we have an understanding of what the Workgroup wants to do for this one.

**Joe Heyman, MD – Whittier IPA**

I think the concern is the health improvement part rather than the need part.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah, what I'm hearing –

**Joe Heyman, MD – Whittier IPA**

I may be wrong.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

What I'm hearing is that the emphasis here needs to distinguish between the need related to health care and the software as a tool to meet that need and certification as part of addressing the software side of the things, that the certification process itself is not going to result in improved health and the software in and of itself is likely not going to result in improved health but is going to enable a program that's addressing improving health.

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

So, would changing address to help facilitate capture the concern or is there other suggested language that we can pop in here?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I guess I'm hearing things like the statement itself is fine but we need to recast the examples.

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

Okay.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, for example information exchange for all providers, well what need is that meeting? That's meeting a care coordination need perhaps, you know, is that part of some bigger need, is that one of the half dozen things that HHS has identified as strategic needs.

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

Okay, so then in the example we can identify example of needs being triple aim or ONC priority goals and then exchange and adoption as part of a care coordination kind of bullet.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Right –

**Joe Heyman, MD – Whittier IPA**

I think we think the examples are fine and that they're actually things that we would endorse, but we think that calling them health improvement needs is too broad. Have I got that wrong?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

No I think that's right Joe and what I'm thinking is I like that this begins with a well-defined need but I think we need to create the linkage to we believe these tools are actually a means to that end and we should be explicit about that, that they're part of a way to achieve the end, that they are not themselves the end.

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

Okay.

**Joe Heyman, MD – Whittier IPA**

I don't think – I guess what I'm saying is we don't need more examples what we really need is a better title.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay.

**Joe Heyman, MD – Whittier IPA**

But I don't feel strongly about this so I don't want to make – I don't think – that's why I said maybe off line people can just think about it and –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

We'll work on the title and creating a linkage, because I really like the title but I think we're misapplying it.

**Joe Heyman, MD – Whittier IPA**

Okay.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, we'll work on tuning it. So, the next slide continues this discussion but I think given what we've just said these also need to be refocused in that same context, again, we're continuing examples like emerging payment models, but again, the reason for the model is around health needs.

**Joe Heyman, MD – Whittier IPA**

Right the models are also tools.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes, exactly.

**Paul Eggerman – Businessman/Software Entrepreneur**

I don't understand – this is Paul again, I don't understand the example. How does certification increase provider participation in an emerging payment model?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I could be very narrow focused in my response and point out that federal ACO Program requires 50% of physicians in the program are Meaningful User's under HITECH.

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah, but that's – I understand how that can be for Meaningful Use but this is the – this is something about the Non-Meaningful Use people like how would certification increase participation by an extended care facility in an emerging payment model?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So –

**Paul Eggerman – Businessman/Software Entrepreneur**

I just –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, having a system that is perhaps modularly certified to receive and send care summaries.

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah, but that's one communication thing but it's not all of certification.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

That's correct. It might be that an appropriate program is not as broad as the one that we have for Meaningful Use certification.

**Joe Heyman, MD – Whittier IPA**

It might mean that you could argue that it doesn't apply to long-term care and therefore maybe one of the reasons why we don't chose it, certification for this. I mean, I hope we haven't created these models in order to find an excuse for certifying long-term care.

**Paul Egerman – Businessman/Software Entrepreneur**

And there is sort of a history of these things with the payment models is usually – certainly for individual providers is sort of like the software follows the model it doesn't lead it.

In other words, you know, integrated delivery networks provided physicians with EMR systems as part of bringing them into their networks it wasn't the other way around, it wasn't that physicians would get an EMR system and an idea in which "oh, great you've got one of these computer systems therefore you can join my network."

Because it's just – in other words I like the examples on the previous screen it's just this one I'm having a little trouble with. I also don't understand the second thing, public health integration what does that mean?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So we have public health reporting requirements in Meaningful Use and so I think we're meaning to put public health on this list as well as things to consider.

**Joe Heyman, MD – Whittier IPA**

That's another Meaningful Use thing.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes.

**Joe Heyman, MD – Whittier IPA**

In any event public health integration, I mean, if you can send a direct message you can do public health, so, that's why –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah, yeah, so you're pointing out that in fact the certification piece maybe the elements that already exist under modular certification, that that might be our conclusion when we look at behavioral health, it might be I don't know want to prejudice that but that might be the conclusion. Oh, the pieces that we actually care about already exists as modules, if people want to certify against them that would be great, if they don't there is not a regulatory requirement that they do.

There may be a business requirement that they do and that's what I'm hearing out in the marketplace is in fact the market is saying to providers if you can't receive using Direct and you can't receive care summaries and you can't send me care summaries I don't want you in my preferred network.

**Joe Heyman, MD – Whittier IPA**

Okay.

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

This is Joan, I wonder if we could think about adding another example here which would be a need to improve the safety of healthcare and the certification process would hopefully improve the safety of the software.

**Joe Heyman, MD – Whittier IPA**

Does it do that? Is there a safety part of certification now?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

There is a quality piece and a user interface piece, yes, which are both intended to make it safe.

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul, I think you could also make the argument that the decision support, the computer aided ordering of medications for example is improving the patient safety.

**Joe Heyman, MD – Whittier IPA**

But I think we're talking here about the safety of the software itself as an example and –

**Paul Egerman – Businessman/Software Entrepreneur**

That's what I heard Joan was suggesting, I thought she was talking about patient safety.

**Joe Heyman, MD – Whittier IPA**

Oh, I thought – I misunderstood then.

**Paul Egerman – Businessman/Software Entrepreneur**

Did I hear that wrong Joan?

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

I was suggesting both.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

**Joe Heyman, MD – Whittier IPA**

Because I thought that there was sort of a division of labor, you know, that the FDA was looking at safety and ONC was – I mean, safety of software as a medical device type of thing. Anyway I don't want to make it more complicated.

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

Well, ONC also has an initiative to look at the safety of EHRs aside from the medical device arena.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so let's move onto the next slide, I'm going to set this one to rest for now, thank you. So, how it would interact with existing federal and state programs.

**Paul Egerman – Businessman/Software Entrepreneur**

This is Paul again –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So –

**Paul Egerman – Businessman/Software Entrepreneur**

I'm sorry go ahead Larry.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I was just going to lay out some of the examples, but go ahead Paul jump in.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, as I look at this I think that this was good framework again it's a title thing, I'm not sure it improves existing programs. I like the word alignment with existing federal and state programs, but that – that makes sense to me.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, an editorial thought there.

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

This is –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

It also gets us out of the judgment question as well.

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

This is Jennie, I was just going to add an additional comment that potentially one of the ways that these systems – one of the functions these systems could support is supporting federal and state programs Medicaid eligibility determinations for example.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah determining, this is Paul, determining Medicaid eligibility – that example sort of causes me to stop because that's something I usually think about in sort of an insurance or payer function as opposed to on the healthcare side, but I guess if we have a broad enough focus here that you could be talking about, you know, insurance –

**Joe Heyman, MD – Whittier IPA**

A provider trying to make sure that the patient is eligible.

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

Right and then the area of long-term care in addition to financial considerations also functional status and other clinical information is sometimes taken into account.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, Jennie am I correct in saying that you're pointing out that in some of these care settings there is a close linkage between what's documented and then subsequent payment which exists in the acute care and ambulatory, you know, ambulatory and hospital settings as well.

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

Correct.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And I guess jumping ahead to the next one when we talk about what's in the pipeline there have been some updates to the HL7 Consolidated CDA to represent some of the data needs in these spaces. So, I guess what I'm seeing in this mandated assessment piece for example is, my understanding is that today these assessments are required in various care settings and that the assessment needs to be submitted electronically, but there is no testing program related to the ability of the software to create those assessments and send them electronically.

**Joe Heyman, MD – Whittier IPA**

I wonder if the word improvements is the right word because when I look at the examples these are not improvements, these are things that are in place.

**Paul Egerman – Businessman/Software Entrepreneur**

Joe that was my comment about, you know, alignment or maybe even compliance, or participation or something, the word improvement in the title is not quite right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah I think alignment is a great header for that.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, I mean or participation or something, but, yeah.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah. Well, if you will we're going back to the C in ONC, we have a variety of federal programs maybe it would be helpful if they aligned a little bit better and with better coordination.

**Joe Heyman, MD – Whittier IPA**

You can't even do that within the government I don't know how we're going to do that here.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And I guess my sense is that the whole quality measure development effort in fact would benefit if it was heading down the path of electronic measures based on clinical documentation. So, some of this is directional and some of this actually might be certification related.

And I think as we look at the different examples in behavioral health and LTPAC that we should be asking these questions. Are there existing requirements in these sectors, how are those needs being met and is there a clarification that comes to a certification program, we're basically asking the question of where is the value of the certification piece of that.

**Joe Heyman, MD – Whittier IPA**

I think you could also ask the adverse which is –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah.

**Joe Heyman, MD – Whittier IPA**

Is Meaningful Use concentration on certain measures shortsighted because it takes attention away from those areas like behavioral health and other things, you know, the government has a whole bunch of measures that they're trying to measure but maybe attention is taken away from other entities just because these are the big money groups chronic care measures.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah, wow, there might have been some interesting questions that I've asked earlier in our work.

**Joe Heyman, MD – Whittier IPA**

Well, I would have hoped that somebody would have asked it way before our work.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I don't mean our work now, I'm thinking going back to the earlier spaces of Meaningful Use – Okay; let's move onto the second slide in this for factor two. This was looking at some other programs from other examples – patient centered medical homes, state innovation models, accountable care organizations.

**Joe Heyman, MD – Whittier IPA**

Those are really sort of the same examples, but that's fine.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes. Well, let's move onto factor three, so next slide, pipeline considerations.

**Joe Heyman, MD – Whittier IPA**

I think this is a really great criterion and I would hope that somehow when we're actually looking at this criterion that we actually get some official sort of – well, maybe not official is not the right word, but some reliable information about what's really out there rather than just some anecdotal stuff. Because we may find that there's plenty of stuff out there.

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul, I think this is a great criterion also as long as it – but I want to make sure I understand it, because we ask the question are there existing Health IT standards, functionalities to support certification. I mean, do I understand that the answer has to be yes before it will be included in certification, in other words, it's not like the government is just going to make up new standards or capabilities out of like a whole cloth it's got to exist already before it can be part of certification, is my understanding of this correct?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

That was my intention.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah.

**Joe Heyman, MD – Whittier IPA**

Well that's interesting because I wasn't even thinking of it that broadly but I'm willing to. I was thinking of it in terms of the pipeline being what's already out there in the way of tools that can accomplish the things that you're listing here.

**Paul Egerman – Businessman/Software Entrepreneur**

No, I'm thinking about it in terms of the fact that on the previous slide somebody asked about Medicaid eligibility you would only create a certification about Medicaid eligibility to the extent that that functionality already exists in the marketplace, right?

And you're only creating information exchange standard about how you going to communicate, again the same thing to the extent that that standard already exists somehow in the marketplace that what you might end up doing is picking and choosing where there is – you know one way to think about it is like if 90% of everybody is already doing something in a certain way then you don't need a standard, right, and you don't need certification, it's sort of more of an issue of like 20% do something some way and 10% something else, and, you know, and everybody is doing something kind of similar but not quite then standardization and choosing, so like one makes sense.

**Joe Heyman, MD – Whittier IPA**

I guess I would argue that in spite of certification we still have CDAs that don't talk to each other.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I think you're right, this isn't going to be perfect Joe, maybe perfect is even too strong a statement right? Will this help get us down the road in terms of pipeline I think that there very well might be a process of we want there to be something so at a policy level they might say we need to have a way to exchange documents that can be imported into the receiving EHR and we don't think there is something very good out there yet.

So, it would in effect say we can't certify that because we don't have a standard, but it might in fact spin up some other activities like the S&I Framework –

**Paul Egerman – Businessman/Software Entrepreneur**

But you have to have something operational –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

In a way – standards.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, I mean you have to have something operational before you can make a national rollout. You're telling me Larry we're in agreement?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah, I think we are in agreement. I guess all I'm saying is this process might – the process of applying the train work could surface, oh, you're trying to do something there isn't a standard there yet before you can go ahead with this you need to make sure that there is in fact not just a paper standard but there is something that's actually in use and that's been the challenge – that's been the challenge for the Standards Committee all along is that they were handed things from Policy Committee saying we want to go in this direction and it was, if you will, disconnected from the current state-of-the-art for there being a standard. So, maybe we're trying to learn from that.

I think the second – the bottom question here is really looking to address that, is there a new Health IT in development even if not mature that could benefit a setting or functionality under consideration and then I think the question here is, you know, sort of to Paul's example, if you've got something that's at a 5 or 10% adoption level is that sufficient to say, you know, proof of concept, if you will, it's there, it is being used by some providers, it could be the basis for a national rollout if there is a threshold in there below which there is not enough adoption to push above which, you know, if it's at 80 or 90% there is probably no benefit in having certification because it's operationally already there. Is that sort of looking for a sweet spot, something that we should be commenting on as well?

**Paul Egerman – Businessman/Software Entrepreneur**

I don't understand the question you're asking Larry when you say something else we should be commenting on?

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

Hi, this is Stan, I think that is a good comment, I mean, I think there are things – I mean, coming from the, you know, the standards part of this, you know, I'm thinking about FHIR, I'm thinking about some of the modeling initiatives that establish a better pattern for what full descriptions of data look like that can be more useful. So, yeah, I think that is a good comment and I think it's – and it's the right standard that it's been implemented and there are people using it even though it's not a majority yet.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I guess I also heard something in our earlier discussion Stan that maybe would be useful to note here although it's actually a little bit off topic, which is that when requirements were brought to the Standards Committee around functionality for consideration in Meaningful Use they were very tightly focused or relatively tightly focused use cases and so the broader question about what do we need to actually have good interoperability hasn't been addressed by the Standards Committee and might in fact be a useful thing to address at some point separate from specifically what we're being charged to do.

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

Yeah, I would certainly agree with that.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so I will – I think that ought to be something we do comment on, but separate from this framework. Okay, well let's go onto our next slide please. So, factor four stakeholder support.

So, I guess the examples here are that the feedback from the request for comment that ONC and CMS put out was that the stakeholders were saying we want full-fledged EHRs in our space but they're not exactly the same as what's required for Meaningful Use and so in many ways like the physician specialty practices we want things that actually meet our needs or the recent amendment to standards related to dentistry to include procedure codes that dentists use.

**Joe Heyman, MD – Whittier IPA**

So, I think they should look very carefully at what happened to the specialist's Meaningful Use requirements and be careful what they ask for. But in any event, I think this is fine. I just want the second bullet there is what I was thinking about as far as the pipeline was concerned, which is what's out there already.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

That's out there –

**Joe Heyman, MD – Whittier IPA**

Yeah, let's have more than just some anecdotal remarks about what's out there, let's have some actual survey of what's out there before we make any finalized decisions about what's necessary.

**Paul Egerman – Businessman/Software Entrepreneur**

I also want to – good comments. I also want to ask about that first bullet example need for enhanced EHR functionality, is that consistent or inconsistent with what we just said that everything has to be already out in the marketplace?

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

Larry, this is John, is that EHR functionality also EHR/EMR or are we just talking about transition from a skilled nursing home to a hospital or are we talking about the EMR that's in the nursing home and home care agency and behavioral health?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

John, you must be the last of purists.

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

I know.

**Joe Heyman, MD – Whittier IPA**

I think we're talking about all those things myself, but I certainly think we're talking about the EMRs that in the place.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes, I agree. The intention here is to address what's running in the care setting and what's used to communicate across care settings.

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

Got you.

**Paul Egerman – Businessman/Software Entrepreneur**

And I appreciate that comment, because indeed when I saw EHR I did think about that broader concept that includes the EMR, but is the purpose of certification to get an enhanced system for LTPAC or is it to simply certify and get standardization around capabilities that already exist in the marketplace, in other words, is certification trying to make these systems better or is it just trying to standardize them?

**Joe Heyman, MD – Whittier IPA**

I would have thought it was the latter, but –

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

Yeah, because – this is John, one of the things that just Larry and Jennie know my windmills, but, is that the EMRs not the ones that are already installed out there because I've been giving a lot of lectures to user's groups and the main thing that they say to me is "John, get the nursing homes and the home care agencies to update their systems to the robust EMR that I got."

And a lot of them are working on analytics and longitudinal so I think getting out that misperception when you do an audit of the marketplace you'll see that there is probably not very much functionality installed in these types of care settings but when you talk and see what the vendors are offering and I just did an RFP for 9 different vendors for a little small nursing home chain and home care chain in Texas and they're very robust and a lot of them – and they're installed and being operational, but they don't show up on the big study.

So, I think getting those misperceptions out there and really what is there and then to answer your question, they're getting certification on those, the four or five that already have certification mainly to show that they have interconnectivity and interoperability with a CCD and a robust CDA.

**Joe Heyman, MD – Whittier IPA**

Which I think is what's most important.

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

That's right that interoperability Joe, you're absolutely right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah –

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

Mike Lardieri –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I would like to extend that discussion because having looked at – taken some initial path, not very scientific just with a few of the vendors who usually sell into the LTPAC behavioral health space have certified in their applications. I was struck by some surprising holes, so not all of them have certified to demographics and you would think that what was in Meaningful Use for demographics isn't a big stretch so I think there's actually going to be some interesting lessons here to Joe's point about specialists of, well what in demographics was hard or almost none of them have certified to vital signs and –

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

And I agree with you Larry and –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And that there –

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

The thing isn't finding out that, because I think some of the guys did some modular's just so they could advertise that they have certification because again, most of our users or providers don't actually understand the whole issue of HITECH.

**Joe Heyman, MD – Whittier IPA**

Well, I guess what I would say here is that if you don't need to have that stuff – if you're not certifying so that somebody can achieve Meaningful Use and get an incentive there is no reason to certify that you can record vital signs, I would bet you that most of the people who haven't certified for vital signs can support them.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes.

**Joe Heyman, MD – Whittier IPA**

And that most of the people who can't – who haven't certified the demographic part can support it and that the reason they have it in there and that they can support it but don't need certification is because the marketplace itself makes them have to have it and it also doesn't require them to certify it.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I guess what I'm looking to do – so I agree with you that that's sort of the – you know, part of the answer and the other part is I'm looking to actually get either better groupings or better understanding of what is in certification because I actually think that there is value in being able to say there are common features that are across the board and that if you are collecting vital signs in one space that you have those available to send along to other consumers of vital signs, other people wanting to know patient status and that would be useful. And my guess is that in that case of vital signs the roadblock is growth charts and that these are care settings where in general no one is interested in growth charts but that's bundled into the requirement –

**Joe Heyman, MD – Whittier IPA**

That may well be.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

For vital signs.

**Joe Heyman, MD – Whittier IPA**

But if they certify for a CDA they must have a way of getting vital signs into the CDA.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Well, but they could get them in without coding them for example.

**Joe Heyman, MD – Whittier IPA**

Right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, how useful would they be?

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul, this is an interesting discussion, my question still goes back to that example of enhanced EHR functionality on the screen. I mean, I can see where the standardizing and certifying around vital signs and whether growth charts makes sense, but I just – the part that has me nervous is I don't want to be thinking that certification is somehow going to be the engine that enhances existing functionality that creates new things that seems inconsistent with what we said before in the previous framework factor. So, it's just the example I'm kind of tripping over.

**Joe Heyman, MD – Whittier IPA**

Well what certification did with Meaningful Use is it forestalled these EMR companies to find ways to measure the things they were already providing that's basically what they did and –

**Paul Egerman – Businessman/Software Entrepreneur**

Well, certification –

**Joe Heyman, MD – Whittier IPA**

–

**Paul Egerman – Businessman/Software Entrepreneur**

Certification criteria for Meaningful Use was at a very minimal level.

**Joe Heyman, MD – Whittier IPA**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

There is nothing about the current certification that indicates you have an enhanced EMR system or an excellent EMR system.

**Joe Heyman, MD – Whittier IPA**

That's true.

**Paul Egerman – Businessman/Software Entrepreneur**

Or if –

**Joe Heyman, MD – Whittier IPA**

Matter of fact in some cases it's –

**Paul Egerman – Businessman/Software Entrepreneur**

It's a minimal level of functionality.

**Joe Heyman, MD – Whittier IPA**

And in some cases it decreased functionality or usability. In other words –

**Paul Egerman – Businessman/Software Entrepreneur**

Well that could be but that's why I –

**Joe Heyman, MD – Whittier IPA**

In other words –

**Paul Egerman – Businessman/Software Entrepreneur**

I'm still having trouble with the word enhancement, maybe it's just me, I don't want to hold us up.

**Joe Heyman, MD – Whittier IPA**

No I think the –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so –

**Joe Heyman, MD – Whittier IPA**

Original point that was made, that you made, originally was that in an earlier slide you emphasized what was out there now and this is implying that somehow you're going to produce something that's new.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I think the wording around here with enhanced EHR functionality, given all this discussion, is in fact problematic and what we're hearing – I think maybe the more accurate statement is that the EHR functionality that the stakeholders would support is not exactly what EH and EP requirements are –

**Joe Heyman, MD – Whittier IPA**

I would certainly –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And perhaps enhancement here more around a better criteria or a different criteria, so again, enhanced is probably not the right word.

**Joe Heyman, MD – Whittier IPA**

And I guess here again I would ask that we would not have anecdotal evidence but actually have specific evidence that there is genuinely a need.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes.

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

Yeah, hi, sorry I'm joining late, this is Mike Lardieri, from the National Council for Behavioral Health.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Welcome, Mike, we introduced you in your absence earlier thank you for joining us.

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

All right thanks, and just on this point we're talking – although I am coming in late I think I am getting the gist of it, on the behavioral health side I would agree I don't want to enhance the EHR functionality I would want the functionality of the EHRs that are not certified at least to mirror what other EHRs are required to do around – to start with just exchange of information.

So in terms of code sets where information is there and it is the same make sure they all use the same code sets and the same structures and can actually pass a CDA back and forth, it may not be complete – it may not have vital signs like – or growth charts like many medical EHRs need to have, but if there is data that is the same then it should be standardized according to the same standards that everybody else is using so that data can actually be shared.

**Joe Heyman, MD – Whittier IPA**

So, Larry, this is Joe, this sort of goes back to a meeting or two ago when all of us looked at this and most of us suggested that if we could just show that they can do a CDA that would be adequate and that maybe we don't have to go through this huge process for this. Because now we're hearing from two of these entities that really all they need is to have a standardized CDA.

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

I would just like to, you know, add to that – I mean, that's where I would start and if I were to prioritize I would start with that and then I would move to quality measures and make sure they're on the same quality measures that everybody else is on and then after that move to clinical decision support as the third priority, but I think that –

**Joe Heyman, MD – Whittier IPA**

So, wait a minute, so you want to have – for your quality measures do you want to have the ability to have taken a blood pressure and a height and weight?

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

Well, for my quality measures there are now 18 that are specific for the behavioral health sector, there are now 18 that are specific to behavioral health that come into play with Meaningful Use Stage 2. So, I would want those EHRs that are behavioral health that are serving providers that can't get Meaningful Use dollars to be able to step up and be able to calculate and provide those same quality measures, because that's what everybody else is going to be using and then that's the next step after your sharing a CCD that you want to be on the same quality measures so if you're working with an accountable care organization or somebody else you're actually supporting them in their work and not out in left field. So, I would look at it in that vein.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, this is Larry, so I guess what I'm hearing is that going back to our earlier conversation about alignment, so this would be a statement of you don't want to require all of the quality measures that might be across the board but the ones that do apply in the care settings should be consistent with what the other providers are reporting.

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

Yeah, I would support that, yes.

**Joe Heyman, MD – Whittier IPA**

Okay, well this is Joe; I'm going to shorten the rest of the conversation by dropping off, but thank you very much for putting up with me.

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

Hey Joe, this is John, I do want to emphasize that it has to be quantifiable and not anecdotal because we really need to know specifically what this segment, behavioral health and LTPAC, can and cannot do.

**Joe Heyman, MD – Whittier IPA**

I agree.

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

And it has to be very quantitative because I'm personally tired of fighting for it and not having people understand what we do.

**Joe Heyman, MD – Whittier IPA**

Well, thank you John and I agree with you.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I also think that the discussions as we look at LTPAC and behavioral health will dive into these details.

**Joe Heyman, MD – Whittier IPA**

Great, so long.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Thanks.

**Elizabeth Palena-Hall – Office of the National Coordinator**

Larry, can I jump in here a second? This is Liz, I just want to, after this next factor that is going to be discussed can we just do a quick recap of what was heard?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

We can work on that I might turn to you to give me that quick recap.

**Elizabeth Palena-Hall – Office of the National Coordinator**

I was thinking just a summary to make sure we heard everything, okay.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so let's move onto the next slide which is factor five, thank you. So, cost benefit. So having looked at all these other factors and now looking to them and sort of dive into, so where do we stand, is this going to be a good thing to move ahead? Is certification really the right option for a meeting that health improvement needs? And what are the costs and benefits for getting there and given all the comments we've had about wording any suggestions about better names for this are also welcome. Everybody is worn out.

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

So, Larry, this is Jennie, I'm wondering about that word "best."

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

All right.

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

Of the options available is certification an important option? Maybe the best option might not actually be available.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay.

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

This is Joan, the only other way of saying this I could think of, and I don't know that it's better, but barriers and facilitators.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, let's –

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

This is John, I think we have to have cost in there because we have to realize, especially when we go, and I know we won't get incentive money, but one of the other problems we've always had is that we don't know what it costs to bring our sectors up to speed so it would be good especially, and this is what Paul Tang said way at the beginning of this call and I don't know whether it fits here or where it fits, but in the new pay models of bundling and risk sharing and all that we have to know true cost in order to be able to share that risk with the hospitals and the other caregivers.

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul; I thought when it said cost in this framework we're talking about the cost of the certification though not the cost of providing health care.

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

Oh, you're probably right Paul.

**Paul Egerman – Businessman/Software Entrepreneur**

And my –

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

But if the guys have to bring their software up to some speed that's a cost as well.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, at least that's the way I interpreted it, I don't know if that's correct or not but yeah that's the second question what are the cost benefits of certification and my view of that is this is an important aspect because, you know, like the previous slide talked about the stakeholders well one of the stakeholders is the vendors and if you've got a program that is entirely voluntary and there is no, you know, there is no incentive program on the part of any purchaser, you know, this thing has got to be fairly inexpensive for vendors to do, otherwise they're just not going to do it and so you are going to have a certification program that is – nobody uses.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Right and I think we'll see that there are some examples of vendors have chosen – vendors not selling complete EHRs, not selling to eligible providers have nonetheless chosen to get certification for some of the modules, so we kind of have an existence proof of some people will do it and –

**Paul Egerman – Businessman/Software Entrepreneur**

Sure.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And it would be good to get some input on so why did you decide to do it, where did you see value or where did your customers see value?

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

This is John a lot of them have done it with the security and privacy because bringing up a thing we talked about in standards every once in a while there is a trust in the data that you're getting so they want to make sure that the hospitals know that they have certification for security and privacy to gain that trust.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so I'm hearing some suggestions around should we broaden this in our language to also look at barriers in facilitation but I do think that the focus that cost benefit gives is in fact part of it was intended here.

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

And this is Mike I'm not sure how it fits in, but I think it fits in because it may only have a cost and benefit or have more of a cost and benefit with those organizations that actually are somehow connected with these new payment scenarios, so if you're connected or you're partnering in an accountable care organization or a patient centered medical home, or a care coordinating program then, you know, having these capabilities are going to be more important for you then organizations that aren't connected so it's almost like you have to be connected to one of those types of programs for it actually to make sense for the system of care you're in.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Well I think we're seeing some of that as the drivers in the marketplace, I agree with you providers need to be connected to other providers as part of the emerging payment models and they're looking to say and "I have software that will help me participate in the ACO, in the bundle payment program."

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

Right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And to your earlier comments Michael about the standards for quality measures that has been my experience is that 33 CMS quality measures as part of ACOs don't really work well in all of the care settings and for the kinds of patients that are being seen in these settings. So, I think –

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

Yeah, this is John and –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Broadly.

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

As Paul knows the, you know, NQF is trying to harmonize those quality measures across care settings and it's where I think standards would help out as well not just in the transitions of care and the other things, but in those eQMs I think we have to have some standards, otherwise I think somebody will be normal in one setting and abnormal in another and their own health will not have changed.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Well that's true and also if we're going to go there I'll raise the ugly issue of goals, but I think that's actually off topic for certification programs, right? It's relative to your goal is, are you in good health or not?

Okay, well to Liz's request about can we do some kind of overall summary here? I think in terms of the defined need, the first factor, there was a lot of discussion about distinguishing ends from means and that we should be clear about that the health needs are for example the overarching needs that HHS has identified and perhaps some more focused aspects of those needs that ONC has identified and that the software becomes a tool and certification of software becomes a tool to help support those needs and we should make sure our language is clear about that and creates a bridge between this is a health need and this is technology which helps meet that need and then there are certification programs around standards to address that need.

**Elizabeth Palena-Hall – Office of the National Coordinator**

Is there general agreement on that? I guess I want to go like factor by factor to make sure we have general agreement on each one.

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

And I would agree with Liz, just to make sure that we have the language right, especially since the next call will begin with LTPAC just to finalize the language here so that the next call can start straight with LTPAC and then make sure we have everything as the Workgroup would like to see it here.

**Paul Eggerman – Businessman/Software Entrepreneur**

This is Paul, what's the next step? Is this going to be presented to the Policy Committee before we start LTPAC?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, we're going to be presenting an update to the Policy Committee likely the beginning of December.

**Paul Eggerman – Businessman/Software Entrepreneur**

Okay.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And my sense is we are not at the place of being able to put forward recommendations around a framework but I would like to present this is where we are in our deliberations.

**Paul Eggerman – Businessman/Software Entrepreneur**

So, a couple of questions. How does this framework relate to the original framework that was set up for certification? Which coincidentally also had five factors. Is this framework only for the new stuff or does this framework impact the existing certification program and the original approach that we've made for certification?

**Elizabeth Palena-Hall – Office of the National Coordinator**

So, the focus of this is for the ineligible providers.

**Paul Eggerman – Businessman/Software Entrepreneur**

So, there's two frameworks one for the eligible – one for eligible hospitals and eligible providers and then a separate framework only for ineligible ones.

**Elizabeth Palena-Hall – Office of the National Coordinator**

Yes, right, because this is not directly tied to Meaningful Use.

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

Well, I would add more to that, I would also say it's not at all tied to Meaningful Use.

**Elizabeth Palena-Hall – Office of the National Coordinator**

Yeah, yeah, okay, being explicit.

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

The goal here is this would be completely apart from Meaningful Use and even though we know the Workgroup did not like the language of voluntary we've taken it out but in essence it would be something that depending upon your setting or in the functionality interest that you could decide to do whereas with Meaningful Use it is voluntary but there are incentives attached to a care that would not be, so it would be much more of an optional program, I'm trying to not to use the word voluntary, so these factors would feed into that in terms of ONC's consideration going forward.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, let me disagree, I think that in fact this is a framework that should work for any certification program but we have very specific cost benefits, if you will, around Meaningful Use, there are incentive payments that are going to fund this.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, but the original framework had some very clear statements that said it was limited to Meaningful Use, that there was going to be a lot of focus on information exchange, there was going to be a lot of focus on privacy and security, there were comments about level playing fields for open source and self-developed software and so none of that is here and so if this replaces it then we've got to go back and say, well what about the level playing field, you know, what about open source software.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

And I think –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, Paul I think those are really good points, I would like – I think we should bring that forward. I don't want to delay the dive into the specific stakeholder areas, but I think that we should bring forward those other pieces.

**Paul Egerman – Businessman/Software Entrepreneur**

So, then you're going to have – so we have to take those and say we're going to end up with like instead of five factors like eight or nine, you know, because we also talked about like the need for modular certification that you don't have to buy a complete package.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Right, right.

**Paul Egerman – Businessman/Software Entrepreneur**

You can buy individual modules and assemble it, so those concepts are going to be somehow be grafted onto this.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I have to say that I have internalized those and I was assuming that in fact we would be extending the framework to do that. That we would continue modular, we would continue that this is open to all levels of software developers.

**Paul Egerman – Businessman/Software Entrepreneur**

But then you're also assuming this applies to the Meaningful Use Certification Program, because that's potentially a significant expansion, right, because the Meaningful Use Program only does certification related to Meaningful Use with a number of exceptions, but, you know, it's supposed to be focused on Meaningful Use as opposed to a broader is there a need in the industry and so that's the part I'm trying to understand, it seems like that's a major change.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I guess maybe the question is around need, right? So, we started this with talking about healthcare need but there could be a regulatory need.

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

Wouldn't – this is Elise, wouldn't regulatory need fall under what the Workgroup has as the second factor potential improvements to existing federal and state programs, would that possibly capture it?

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, but again, my point is the current certification program for Meaningful Use did not include that concept of regulatory needs and so my question is, are we expanding this, in other words for eligible providers are we now also expanding the certification program, is that our recommendation? That's the question or is this only for ineligible that we're concerned about the broad concept of regulatory needs.

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

Right, this was – I can answer from ONC's perspective, this would only be for what's been termed ineligible. So, there are certain populations of functionality – population focuses that are not addressed.

**Paul Eggerman – Businessman/Software Entrepreneur**

Yes, but –

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

But this would be completely – now there may be cases where –

**Paul Eggerman – Businessman/Software Entrepreneur**

So, I'm trying to understand, so are you telling me that should be our recommendation? In other words don't we get to make whatever recommendation we want?

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

Whether this should be apart from Meaningful Use or be included in Meaningful Use is that?

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah, I guess you're telling me that we can't recommend that, so okay, I'm sorry I brought the issue up.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, Paul, I think it is the right issue we can recommend anything we want whether or not ONC listens to us is a separate question, but I think that –

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

Right, right, I think –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I've been assuming – I've actually been assuming that the framework developed for Meaningful Use around modularity for example is in fact a key aspect of a certification program.

**Paul Eggerman – Businessman/Software Entrepreneur**

So, let me make a suggestion that we need to dust off that original framework and we need clarity on this. We need to say what is going to be for the eligible side clearly and what is going to be for the ineligible side that would be a useful thing.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah, because I think to our discussion all the examples you brought forward Paul are in fact things that people see as value in these two communities, that they do see the need to state, as John Derr said, that they can ensure the privacy and security of the information they're being asked to handle, that they can create standardized documents, that they can contribute to the quality measures that the larger organization that they are partnering with is asking them to.

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

Right, this is Elise again, I think just to answer part of the question at least, I think ONC has stated in its regulations in the past that there is definitely a devotion to moving towards or continuing to work under the modular certification component and I'm wondering and Liz jump in here if I have it incorrect, but the goal of the charge was to be a little bit I think more focused specifically on the ineligible population as opposed to the larger benefits of a certification program or any certification program in general but really to pinpoint what was – when and where should a voluntary certification come in handy and building upon whatever is in existence for the certification expertise that ONC has developed. But Liz chime in if I have that incorrect.

**Elizabeth Palena-Hall – Office of the National Coordinator**

No, I think that's correct.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so we have some homework to do in terms of pulling out those earlier recommendations.

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

Yes.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And see where they fit against this framework.

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

Yes.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, see if I can do a quick pass through some of the other major bullets. So, under existing programs I think the switch from improved to aligned is in fact the intention here.

I think the discussion around pipeline seemed to support the notion of let's build on existing standards, let's bring in this notion of a sweet spot of adoption, enough adoption to demonstrate that this is real and low enough adoption to demonstrate that there is likely value in clarifying single standards as opposed a cacophony that might be in the marketplace.

In looking at stakeholders I think clarification around EHR, EMR that this is both the system that's used in the care setting and as part of communicating across care settings.

And under cost benefit I like Jennie's comment about important versus best because it might not be best but it might be best available and yes we're talking about the cost of the certification program not the overall cost of healthcare and to our final discussion that we should in fact dust off the early recommendations for the existing certification program. So –

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

Not to open, Larry it's John, not to open up the wordsmithing thing but you might or Liz or whoever is going to send this out send it out to the rest of us and give us like a day to offer any comments on it so it gets it done fast.

**Elizabeth Palena-Hall – Office of the National Coordinator**

Okay, will do, yes, we can do that.

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

Actually Liz this is Elise would it be helpful if I actually send it out a little bit earlier that way some of the advanced work regarding the final language can be done over e-mail and then maybe at the beginning of the next call we can take 10 minutes to present what comments have come in and what the final language is, would that be helpful?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, my thought in terms of –

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

I was sort of saying get it down before then.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, my thought to moving this forward is we should look towards a summary slide deck that we're going to bringing to the Policy Committee and that we should draft that and circulate it to the Workgroup and that we should do that in parallel with getting ready for the first of the LTPAC calls.

**Elizabeth Palena-Hall – Office of the National Coordinator**

Okay.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

My concern is that we could spend a lot more time continuing to tune this and I'd like to really snapshot where we are, dive into the specifics and then come back to these topics based on our experience with the two areas we're going to be looking at. And that whatever we present to the Policy Committee in December is really going to be this is a snapshot of our thinking and we'll get feedback from the rest of the committee as part of that.

**Elizabeth Palena-Hall – Office of the National Coordinator**

Sounds good.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay.

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

And Larry?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes.

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

This is Joan; I think you should feel really comfortable saying that we are behind this five factor framework. I think everyone liked it.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay. Great, thank you Joan. So, let's open this up for public comment.

## **Public Comment**

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

Okay, thanks, Larry. Operator can you please open the lines?

**Ashley Griffin – Management Assistant – Altarum Institute**

If you are on the phone and would like to make a public comment please press \*1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. We have no public comments at this time.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I'd like to thank all the Workgroup members for the discussion and all of our federal partners who joined us. We have a call on December 2<sup>nd</sup>. We will be starting the discussion about long-term post-acute care. We have three of those scheduled and there will be an equivalent set on behavioral health, then we will do a final review of where we are and have some recommendations to the Policy Committee I think we're looking at February or March for that, February for that.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

January.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

January for the presentation, no, no, February.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

So, you're doing a framework update in December.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

In January you're going to do a draft update of where you're at and then hopefully by February you'll have final recommendations.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Very good, thank you.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

Thank you.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay everybody have a good Thanksgiving break.

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

Okay, thanks, Larry.

**Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator**

Thanks Larry.

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

Thanks for all of your work.

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

Thank you.