

**HIT Policy Committee  
Certification/Adoption Workgroup  
Transcript  
April 7, 2014**

**Presentation**

**Operator**

All lines are bridged with the public.

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee'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 – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Good morning, Larry. Marc Probst?

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

Here.

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

Hi, Marc. Carl Dvorak?

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Here.

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

Diane Bedecarre?

**Diane Bedecarre, RN-BC, MS – Workforce Development Co-Lead, Health Informatics Initiative – Veterans Health Administration**

Here.

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

Diane, am I saying your last name wrong?

**Diane Bedecarre, RN-BC, MS – Workforce Development Co-Lead, Health Informatics Initiative – Veterans Health Administration**

It's Bedcarre, but that was close enough.

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

Okay, thank you. Donald Rucker? Liz Chapman?

**Elizabeth Chapman, MS – Program Analyst – Veterans Health Administration**

Here.

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

Hi, Liz. Liz Johnson? George Hripcsak? Jennie Harvell?

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

Here.

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

Hi, Jennie. Joan Ash?

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

Here.

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

Hi, Joan. John Derr?

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

Here.

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

Hi, John. Joe Heyman? Marty Rice?

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Here.

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

Hi, Marty. Maureen Boyle?

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

I'm here.

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

Hi, Maureen. Micky Tripathi? Mike Lardieri? Paul Eggerman?

**Paul Eggerman – Businessman/Software Entrepreneur**

Here.

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

Hi, Paul. Paul Tang? Stan Huff? And from ONC do we have Kate Black?

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

I'm here.

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

Hi, Kate. Kim Wilson?

**Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention**

I'm here.

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

Hi, Kim. Mike Lipinski?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Good afternoon, I'm here.

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

Hi, Mike. Liz Palena-Hall? Is there anyone else from ONC on? Okay, with that I will turn it back to you Marc and Larry.

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

Well it's great to everyone on today. Let me comment on last week's discussion and see if we can learn from it as we go into this week's. We had a lot of very robust dialogue, but it seemed like it took a while to get the full spectrum of folks engaged and opinions out there. So perhaps this time we can be more focused on making sure everyone's variety of ideas get brought forward, so we can record the robustness of our discussion. And then having put all of them out there, to see if we have some kind of consensus would be great and see if we can resolve to an integrated, common point of view that we want to bring forward. But, rather than spend a lot of time cycling among the few participants to try and get everybody engaged early. So, let's see if that will work as general guidelines for this time. Any other comments Marc or Michelle?

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

No Larry, I think that's excellent guidance. And on the other side, it is so good to have the input from this group, I mean; it really does provide depth into what we're talking about. So, thanks for your leadership, Larry.

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

Oh, you're welcome. And I want to be clear, I'm not trying to short-circuit the conversation, but I'm trying to actually make the best use of our time and cover as much territory as we can. So with that, why don't we dive into the specifics for today? We have a couple of slides to jump to. Thank you.

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

So maybe Marc Probst can kick us off.

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

Okay, I don't have the slides in front of me, but I do know this slide, and we are going fly through this topic. So it's about a certification mark, one that's currently used by the vendors and others to show that they've certified whether it's a module or a product. And really the only issue I could discover in this process was the word that's underlined there, which is required. So currently it is not required that the certification mark be there and this requirement – or this I guess regulatory requirement would be that it be required and be there. And that's what we're – that's what we have on this page and that's what we would be putting forth. Does anybody have any issues with that being required?

**Paul Egerman – Businessman/Software Entrepreneur**

This is Paul. I don't understand, what's the policy issue here that we're trying to decide? I mean, what's the benefit of requiring it, who benefits, what are we trying to accomplish?

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

I think as a consumer, Paul, from my perspective, and again, this is just Marc. It would be great to know that it's there and that there would not be any ambiguity as to whether or not something has been certified. And I think that's where it would be helpful to require that it be there, so that people know that it's there, they can see it and they can move forward, they don't have to ask the question whether or not it was certified or not.

**Paul Egerman – Businessman/Software Entrepreneur**

I don't understand from the vendor standpoint, I mean it's required to be there, where is there? What does the vendor have to do?

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

Well, I look to Carl on that, because I'm not a vendor.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

I was going to ask the same question. I wasn't quite sure where there was.

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

Well it looks like this is addressed to the ATCBs or the ACBs they're no longer temporary.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

That's what I was reading into it, I wasn't certain what it meant. I thought that once they certified us, then the fact that we're listed in CHPL was, in fact, that confirming – I thought that was the mark, more or less, that we'd have to cert this as the CHPL number for the product they're buying.

**Paul Egerman – Businessman/Software Entrepreneur**

It has that second bullet I just don't understand it.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Okay, maybe I –

**Paul Egerman – Businessman/Software Entrepreneur**

The second bullet says ensure the use of the mark by HIT developers. I mean it's not like you get a package anymore, like it's a cereal and you can get a box of cereal and there's a place to put the mark. And so I'm just –

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

(Indiscernible)

**Paul Egerman – Businessman/Software Entrepreneur**

– so I mean, I just don't get it, what it is, what it accomplishes or how it helps a purchaser.

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

Well, I'll look to our ONC folks for guidance now.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Okay. This is Mike Lipinski with ONC, but before I jump in, I'm going to see if Kate has anything she wants to say first or –

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

No Mike, go ahead.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Okay. Great. All right, so before this proposal, there were varying marks used by each of the ACBs to indicate what was certified and under what program it was certified. So for consistency and ease of reference for consumers, to prevent confusion, ONC developed a mark for the program. That mark would be used with all certifications done under the program; it would be clear, consistent, one mark for any product certified under the program. And it would help prevent confusion from private sector programs that have their own certification programs. So that was the rationale behind the proposal and use of one mark.

What we require, it's unli – it's not the same as what we require for how you mark it and communicate a certified product, which I think vendors are familiar with that requirement about what they have to put in any marketing materials and communications. But what we're saying is, if you – it's supposed to be issued with the certification and then if you, vendor, were going to use the mark, you just – the devel – the ONC ACB has to ensure that you use the mark consistent with the terms of use, which are available on our website. So it's just simply the color font – it's consistent with trademark law. But we are not requiring that – unlike with the other requirements as to what year it was certified, what criteria it was certified to, we're not placing that requirement on ACBs to ensure vendors are following. Here we're saying you issue the mark with the certification, vendor you can use the mark. If you use the mark, you have – the ACB has to make sure you use the mark consistent with the terms of use, that's it.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Okay.

**Paul Eggerman – Businessman/Software Entrepreneur**

But it seems like there's no like policy issue here, you're just clarifying some things.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Well the policy issue is there was confusion related to what mark was being used, multiple marks being used to indicate certification under the program. Like I said, each ACB had their own mark, different ACBs were trying to register their mark that had like ONC in it, things like that were happening. So there were legal reasons and particularly provider confusion reasons as to why we developed one mark and are requiring for its use for anything certi – it's very consistent with any other certification program that is out there.

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

Well it seems to me that clarity would be pretty helpful, at least as a consumer.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

And like I said, the vendors aren't required to use the mark, but if they so choose to, they have to do so consistent with the terms of use. And I know right now many vendors use the mark given by the AC – whatever ACB had their own mark with their product, I've seen it on a lot of vendor websites; whoever they were certified by, whether it's InfoGard or CCHIT at the time or so forth.

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

So I guess the policy issue here is creating a single ONC mark for this program.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Correct.

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

But not to use it, is that what you're saying, Mike?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Ah, the ONC ACBs have to use it but the vendors have choice, if they choose to use it, they have to use it consistent with the terms of use.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Seems okay, it's like the CE mark or something, right? If you put that on your product, there's a standard –

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Right, exactly. Very similar to that...program or use of trademark.

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

And the vendors want to do that because it shows differentiation. This is John Derr.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Well, it'll be a puzzle because remember in a modular world, there may be pieces and parts that are and pieces and parts that are not. But, I don't know that it'll matter a whole heck of a lot, I think we'll have minor confusion with that world anyway, we'll have to deal with, so I'm guessing it'll be okay.

**Paul Egerman – Businessman/Software Entrepreneur**

And we're actually going to talk about this Meaningful Use and non-Meaningful Use thing in a minute. Is it still one mark regardless?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Right, it's just a mark to indicate it's been certified under the program.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

And the – so the – it's presumed that it's not attached to the vendor, but that it's attached to a specific set of features described by the vendor?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Well really what our – we would anticipate – so, like I said, it's to prevent confusion so we don't have all these different marks being used. So there's one mark, a vendor has the choice to use it. We assume that a vendor will want to use the mark, because they're going to want to indicate that their product –

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Sure.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

– was certified under the program. So it's well it's requirement on the certification body but vendors have choice, but the assumption being that they will probably choose to use the mark so they can indicate that the product – simply indicate that the product's been certified under the program.

**Joseph M. Heyman, MD – Whittier IPA**

So this is Joe. If I'm a consumer, a physician and I'm buying a software product and it has that mark, aren't I going – wouldn't I assume that that means that its Meaningful Use certified?

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

Yeah, I don't know – I wouldn't –

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

I don't know, I mean that may be a comment that you want to make, a comment may – that may be a comment you want to make, Joe. But we anticipate other products being certified under the program and for other uses, as we said many times in reg, beyond Meaningful Use. So, it's just to indicate it's been certified under this certification program –

**Joseph M. Heyman, MD – Whittier IPA**

No, I understand that, I just think that it might increase misunderstanding and confusion rather than decrease it, that's my point. I don't care.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Okay, I'm – but you know that all the certification bodies, maybe you do not know that all the certification bodies were using their own marks and issuing them with each product that they certified –

**Joseph M. Heyman, MD – Whittier IPA**

No, I didn't know.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

– to indicate that it was certified under the program.

**Joseph M. Heyman, MD – Whittier IPA**

Okay.

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

This is John Derr. Just I think one of the most important modules is that security and privacy and HIPAA, which is the trust module, maybe not to throw a wrench in this whole thing. Maybe we ought to make the definition that at least that module, which is the I trust that information I'm getting from you has been certified, that that should be the minimum that anyone gets – does to get this logo, stamp.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Do you know, will the – when using the mark, we have to be explicit about what pieces and parts are actually certified or how – because it won't really apply to the whole vendor, probably. I guess it could, I suppose, but will there be some requirement about how fine-grained you have to be to articulate what it was that you had certified and under what edition and things like that.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Well that's already a requirement in the –

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Okay.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

– in the Rule, related to your product. So any EHR module has to in any marketing or communication statements, materials, has to indicate what edition it was certified to, what criteria it was certified to, whether it has any relied upon software that's needed to meet that criteria. So if you were using like I don't know, a different security system on top of your product and you need that that would be listed on the CHPL, too. So those are all requirements that already exist that has – they're not associated with the mark at all.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

I just want to make sure, but from a vendor's standpoint, use of the mark is optional, the vendor does not have to do it.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Yes. If the vendor chooses to use the mark, then the ACB has to ensure that they're using the mark consistent with the terms of use, but this does not – this proposal places no requirement on them.

**Paul Egerman – Businessman/Software Entrepreneur**

And just as a side comment is a former vendor is, I always preferred to never use anybody else's logos or marks, I'd always argue against doing that, just because I didn't want to advertise for anybody else except myself.

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

All right, any other questions on this?

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

Anyone who's been quiet has something to say, this is your chance to jump in.

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

I'd move along then, Larry.

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

Okay, let's do it. Okay, moving on to non-MU EHR technology certification.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Larry, do you want me to lead this conversation or do you want to lead it?

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

It would be great Jennie if you would lead it.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Okay. So Larry, Joan, Mike and I had a little sub-workgroup to pull out – to review this part of the proposed rule, look at the questions in the proposed rule and advance our thinking to this workgroup. And in the proposed rule, ONC is proposing to distinguish between Meaningful Use and non-Meaningful Use certified technology products and they established some proposals as to how they would – what the Meaningful Use and non-Meaningful Use modules would have to comply with.

And in the sub-workgroup's opinion, it seemed as if the second bullet that you're seeing on the screen, that only Meaningful Use EHR modules would need to be certified to the automated numerator recording, the automated measure calculation and the non-percentage based measure use report requirements seem to be the big distinguishing feature in the proposed rule, between Meaningful Use and non-Meaningful Use modules. Both modules would have to be certified to the safety enhanced design and/or the quality system management requirements. And that only the Meaningful Use EHR modules listed in the CHPL would have to comply with the subsection (k) (1) (iii).

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

So what is that subsection (k) (1) (iii) say?

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Well actually, I was just going back and looking at that, and maybe Mike if you can quickly summarize it.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

I don't have it in front of me, but that's the requirement for price transparency, so you would have to say for right now and for MU modules if you have to pay for anything else to be able to do MU, so for instance ongoing reporting to a public health agency, things of that nature. So that's that requirement that's specific to MU for price transparency.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Okay, thanks.

**Paul Egerman – Businessman/Software Entrepreneur**

So, this is Paul. I still don't quite get this. So there are some Meaningful Use certifications that do not require a numerator or denominator, they're certification only and when that occurs, is that still an MU module or – in other words, is that an MU module or is it a non-MU module if there's no automated numerator recorded? Do you understand what I'm asking?

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Yeah, your question is, are there instances of modules for which a reporting requirement is not established?

**Paul Egerman – Businessman/Software Entrepreneur**

That's correct and so are those always going to be considered MU modules as a result? In fact, we actually, I think perhaps talking about some of those like the demographic data requirements in at least the proposal for Stage 3, there was no – those are certification only requirements, there was no requirement in terms of percentage usage or anything.

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

Right and so Larry, chime in if I'm misrepresenting the conversation that we had, but in our workgroup we thought that for every requirement there was some form of at least attestation involved in terms of how the requirement or criteria would be satisfied or addressed.

**Paul Egerman – Businessman/Software Entrepreneur**

But there are certification only things, right? I mean Carl, am I missing something here, there are – I'm confused how that fits into this.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

It seems like there are two scenarios as well, one is if you have a module that's not MU certified and then use a different module to do the numerator and denominator, aggregation and reporting. I assume that would be okay, right, so then you're attestation would be involving both the non-MU module and an MU module or is it – would it be specifically prohibited to use a non-MU certified CPOE with the aggregation of numerators and denominators done by a third-party product? If you're an –

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

I think we're raising all good questions that to my understanding were not addressed in the NPRM.

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

Hi, this is Kate. Just to give you a little bit of clarification. As it stands, all MU-related certification criteria must include the G1 and G2 measure calculation, that's just a general requirement we have for each and every certification criteria. So this would remove that for non-MU EHR modules and going forward we would require the MU certification for any provider or hospital looking to attest to Meaningful Use. And other programs that they wanted to leverage are certification program say for behavioral health or long-term care; they would be able to use the non-MU certified product.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

So you're saying that, for example, the certification criteria around occupation, recording occupation. You're going to have to calculate like a numerator and denominator, even though there's no Meaningful Use criteria around that or are you saying that that becomes optional now and vendors don't have to provide that – ?

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

So some of them, as you can see, there's (g) (5) listed are non-percentage based measures. So all the criteria require that for Meaningful Use there's some sort of recording of how many people have done this or how many times you've used it. For things like demographics, while there's not necessarily measures to calculate, there are other reports that are generated that are associated with Meaningful Use.

**Paul Egerman – Businessman/Software Entrepreneur**

I see.

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

So going forward, anytime a provider or hospital uses this technology in order to attest to Meaningful Use, they'll still have to use products that are certified to those three capabilities.

**Paul Egerman – Businessman/Software Entrepreneur**

I see. You answered my question, thank you.

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

So maybe we can move on to the next slide, which I think highlights some of the questions that ONC presented in the NPRM. Right, and so you can see here on this slide the questions that ONC wanted public feedback on. And the first question goes to, is the regulatory burden assumption regarding the EHR technology developers having to meet the automated numerator and automated measure calculation certification criteria correct? And ONC, in the NPRM, thought that there would be some burden associated with performing those – being able to complete those calculations and that was part of the rationale for proposing that the non-Meaningful Use module would not have to support those calculations. And so they're here is, is that burden assumption correct?

Next question was do the automated numerator and automated measure calculation certification criteria pose more of a burden for small developers and for non-MU purposes and settings? And again the – what underlies that question is that developers who are creating products for use by for example behavioral health or long-term post-acute care providers who are not participating in the EHR Incentive Program and don't have to meet the Meaningful Use metric. Does it make sense that those requirements should not be embedded or would not be needed in those types of products and to require those products to include that functionality is it correct that it would just be added burden?

Next question is, would healthcare providers using technology for non-Meaningful Use purposes and in non-Meaningful Use settings benefit from or be hindered by paying or using technology that embeds or includes the automated numerator and automated measure calculation certification criteria. And then last question is how does ONC best implement the proposed approach if ONC were to adopt it in the final rule. Specifically ONC was wanting feedback on would the process for testing and certification be clear under their approach, should technology vendors simply inform the ONC ACBs that they're pursuing or wanting to pursue a certified or non-MU certified module? And how should they distinguish the non-MU EHR modules on the CHPL, should they have a separate listing of MU and non-MU modules? Are there other options? And how should ONC indicate and list the availability of Meaningful Use EHR modules for use beyond Meaningful Use purposes?

And I think on the next slide, you'll see the sub-workgroup's initial thinking about this. We thought it was important that it be very clear as to – consistent with what we were talking about last week, very clear as to what's a Meaningful Use versus a non-Meaningful Use module. And I – we said we supported the optionality embedded in the requirement that Meaningful Use and non-Meaningful Use modules must be certified to either the safety enhanced or quality system management requirements. Mike, I don't know if you wanted to say anything about that?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Yeah, I just want to clarify that there's not really optionality there, if we go back and look at the preamble, how we write it and the reference to the current regulatory requirements. Every EHR module is certified there to quality system management and that would be retained in the 2015 edition. Safety enhanced design applies based on what your module has in it, if it has one of I believe it's eight different medication safety related capabilities. So if you read the sentence, it says as applicable; so in some instances you will have to do both (g) (3) and (g) (4) and in other instances, just (g) (4). So – but those requirements are being re – proposed to be retained for the 2015 edition, for all modules.

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

So Mike, the optionality here or the "optionality" is for the ambiguity around the and/or is it –

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Right.

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

– depends on the module, so if you're using one of the modules that have the safety enhanced design requirements, then you're expected to meet that requirement as well.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Right, you would have to do (g) (3) and (g) (4), correct, you would have to do (g) (3) and (g) (4).

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

And they all require that you provide some information about your quality management process.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Correct.

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

Okay.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Thank you for that. Okay, so workgroup thought that the ONC CHPL should make it very clear to users, which modules are MU certified and which modules are non-MU EHR modules. And we wanted to bring back to this workgroup, particularly those members of this workgroup that are vendors, to comment on the regulatory burden functions in the NPRM related to technology developers having to meet the automated numerator and automated measure calculation certification criteria. Those folks who are on the phone, do you agree that it's – it would – it's – there's some burden associated with that and therefore, in terms of the non-MU certified modules, it makes sense to, since there's no policy applicability of those measurements, why impose the burden on vendors to embed that functionality. Do you agree with that?

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

So let me expound a little bit on the question here. So there's this thread of assumptions in the NPRM about burden and effort it takes to do some things. And so we are basically saying that none of us in the subgroup are developers and therefore it wasn't – it was out of scope really for us to comment on whether including or not including these calculations significantly added to the burden of creating the modules. And in some ways the next section talking about cost to the consumer, there are many factors that go into setting a price on products, some of which are development costs, but there are many other factors that go into setting a cost. And so similarly, we were trying to be relatively neutral in our comments about whether or not this was likely to increase or decrease or not have any effect on costs. So whether it was the burden for the developer to create the software or what got charged through to customers. I believe Carl had to get off for a little bit, are there any other folks who want to comment on the vendor-related issues?

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah, this is Paul; I got knocked off for a few minutes. I have like – do have a couple of comments and again, I am not currently a vendor, but I was formerly a vendor and formally a small vendor, too. In some sense I look at these questions and I'm not sure they're exactly the right questions. Because another way to phrase it would be, for a vendor or a small vendor who might want to do one of these sort of optional certifications, not for Meaningful Use, does the absence of the calculation, is that enough of a regulatory simplification to make them still want to do the certification, because it's still optional. In other words, so the question is, is this enough to make them want to do it all?

Because there is another choice that I would simply put forward, the vendor could just say, well I'll write my software according to all the specifications, but I'll skip the certification piece. I'll just put it in the contract and tell my sales prospects that it does – you'll get like transitions of care, you say I'll do exactly what it says in the specifications, and I just won't go through all of the other stuff. So, that's the question, and actually, I don't know the answer. I also think that there's another question that really we should be addressing, which is, how does the marketplace view this? I mean, is this going to add confusion, are people going to understand the difference between Meaningful Use and non-Meaningful Use? What happens if a small vendor that certifies something that's non-Meaningful Use is competing against a large vendor that is certified for Meaningful Use, will their approach appear to be like junior or less valuable? And I don't know the answer to those, but I think those are interesting questions that might be considered.

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

So Paul, I think you're touching on some of the things that came up in our discussion which was the – and it's come up a little bit already today, right, if a certain module is of value to a non-MU provider, but is part of the MU Program, and has been certified to the MU criteria including the measure calculation. But I don't need all of that, but I want the rest of the functionality, does that create confusion because I'm a non-MU user. And on the flip side, will I think of myself as a non-MU user and therefore be interested in perhaps a slightly simplified module because it doesn't have some additional features, which may or may not be useful to me. Right, it might be useful for me to know what percent of my users are using a feature, whether or not I need to certify that or attest to that to somebody, I still might want to know is it being used.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

I think part of what you were just asking, from the work that we've done in ASPE on non-Meaningful Use providers – providers who are not eligible for the Meaningful Use EHR Incentive Program. They've certainly heard the term, the phrase, Meaningful Use EHR Incentive Program and they know that there is certified EHR technology out there to meet that program requirement or those program requirements. I don't think they know exactly what those program criteria are and I don't think they know that, for example, under this proposed construct, where there would be an MU certified module versus a non-MU certified module. I don't think they would know, at least going in to it, that the difference between their non-MU certified modules is the fact that it does not, it cannot potentially calculate these various numerators and denominators percentage scores. So I don't think the provider would know about that, the ineligible provider would know about that.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, that may be and the issue is it's very hard to figure out how the marketplace will accept anything. I would just still make the observation that you're going to have a competitive environment where you're going to have vendors with non-MU modules competing against vendors with MU modules. And that's the thing I don't know how that's going to work out in terms of will the prospective customer think that one is a junior certification or will they think there's value in the MU one or – that's a bit of a mystery to me.

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

Yeah, this is Larry and Paul; I do have to wonder with you whether or not we're adding a distinction that in the end is going to be relatively meaningless, other than the provider's ability to qualify for MU. And it may not ever move to significant complexity from the module itself, and therefore won't have affected the price very much. But you're correct, it will create the perception that there's something missing from the module that I am buying and maybe I should seek it from a different vendor just because I don't want to have that missing piece, even if I don't really know what it is.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Right, and if you think about other vendors who've not yet participated and secured certification from ONC for their products. And it think that's part of – I think that was part of the question that ONC was asking here, will it be less costly for those new vendors, the vendors who have products or want to have products for ineligible providers, for example, and get those products certified through ONC. Will it be less expensive for them to develop and secure cert – non-MU certification for those products, if they don't have to go through the burden establishing these various measure calculations?

**Paul Egerman – Businessman/Software Entrepreneur**

And my answer is –

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

Yeah, I think we've highlighted –

**Paul Egerman – Businessman/Software Entrepreneur**

My answer to that is probably yes, it would be less expensive, but what I don't know is if it's like enough, if that's enough to get them to certify and also I don't know how the marketplace will handle that. That – and I'm not saying it like – I'm not trying to say it like it's a criticism to say it's not enough, it's just – I'm trying to say, it's a mystery, I don't know.

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

And maybe that's really where we are coming down on this, that we don't know if this simplifies the program or adds complexity to the consumers. Or if it simplifies things sufficiently for the developers to have – to change their behavior, whether they choose to be certified or not and whether they choose to be certified for MU, even if they expect their customers to be primarily non-MU customers. And I think some of it is to the point of it begins to sound like a two-tier program and that the software itself may in fact be somehow not as good, just because it didn't do these calculations when they may or may not be relevant to the customer, maybe doesn't actually affect the customer's perception of quality.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

So this is Mike with ONC. The one thing on the two-tiered comment that I just wanted to mention is if you read this in context with our Request for Comment on other types of HIT – certification of other types of HIT and for other healthcare settings, we refer to this as a first step. So this is what we were able to do at this time, in terms of opening up the program potentially to certification of other types of HIT and for other settings. So, I just wanted to make sure that context was there in terms of this proposal is somewhat tied to that other proposal related to the concern over a two-tier program, I guess.

**Paul Egerman – Businessman/Software Entrepreneur**

And Mike, I appreciate that comment and as a first step, it's a good first step. I mean, there are a number of things that could be considered and should be considered to reduce the burden of certification to make it more effective. And so I appreciate the fact that you're doing that. And a comment like that should be in our response, I mean, we want to make this thing easier and less burdensome to do and so we appreciate ONCs making an effort to do that.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

And I think the other – this is Mike again with ONC, the other question that's essentially embedded in the questions that we asked. I think when we asked about small vendors and do provi – what providers think about this is, how many vendors actually program in like the numerator, so capturing how often this – either this capability was used or how many patients it was used on? We understand that – right now the requirement, just to be clear, for EHR module certification isn't to capture the denominator, a vendor could come forward with a module that can do that, but that's not a requirement, right now it's just the numerator. So I guess the question is, how many products do capture that right now, even – in any setting? And I'm not sure if you guys know that, but that was kind of some of what we were trying to get in terms of information to inform the proposal.

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

I think we are lacking vendors on today's call, so –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, but I think it also it's one of these things you can't give like a firm answer and say like 10% or something – module. And some things are a lot harder and a lot easier to do and –

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

And it probably varies by module as well, don't you think Paul.

**Paul Egerman – Businessman/Software Entrepreneur**

Well that's what I'm saying is it depends on the module. It also, somewhat ironically, depends on whether or not it's existing software. If you have some existing software that does something, it can be a lot harder to do. I mean, for example is the free text requirement in the 2015 edition and you might have like six different places where people can put in free text and so if you've got to figure out and calculate a numerator, but make it once per visit, it can be really tricky to do. But if you've got something else, like some new standard for transmitting data or something and you were writing from scratch, it's actually very easy to just stick in a numerator as part of the development process.

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

And so actually ironically, that might be a benefit for a new vendor coming to the market, because they know they have to do this calculation of –

**Paul Egerman – Businessman/Software Entrepreneur**

Well that's right, so you just design it in, in which case you would do it because it would also expand your market potential, you'd figure, might as well while I'm at it.

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

Right.

**Joseph M. Heyman, MD – Whittier IPA**

Not doing it is what drives us crazy because it changes the work process, because you have to add extra clicks in order to make sure those things are recorded.

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

Well I think to Joe's point, how the product knows that a feature's being used could vary greatly and may or may not show up in the workflow to the end user. So, I think we've captured some highlights of the things that would affect burden to both users and software developers. Are there any other things that we should add to our discussion?

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Well, the ONC had asked some additional questions about whether or not developers should simply inform the ONC ACB that, in terms of the type of certification they're pursuing, whether they're going to MU certified or non-MU certified and the sub-workgroup thought that that seemed to be a fine way to go. Don't know if this workgroup has any additional thoughts on that.

**Paul Egerman – Businessman/Software Entrepreneur**

I don't understand how else you can do it, isn't that the only alternative?

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

That was the only alternative I recall being in the NPRM and in our conversation, I don't think we came up with any others.

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

It seems like it's a basic requirement if you're going in for testing to say, I want to be tested to MU or not to MU, right, and I don't know if it's any more complicated than that.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Yep. We also thought that the CHPL should be very clear in terms of whether or not a module was MU or non-MU certified.

**Paul Egerman – Businessman/Software Entrepreneur**

Can a package be MU and non-MU certified or is it each module has to be separately designated? How does that work?

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

I think in – so if I recall the NPRM correctly, it was talking about it as from a modular perspective, but I think last week's conversation in this workgroup, I think we were struggling then with what's the scope of MU certified.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Let me, let me see if I can clarify that. So you were – so a package only applies to the product that was certified, not a combination of products. So if you're asking whether or not the package –

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

It's a combination of modules –

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

– right, so no –

**Paul Eggerman – Businessman/Software Entrepreneur**

A combination of –

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

We don't do a combination of module certification, we used to do that with – for the privacy and security part before, for like the 2011 edition. But right now, if you came in to meet a criteria or a couple of criteria, whatever products were brought in would be all to meet that criteria together or would be considered one module. Does that make sense?

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

Right, but how does that roll up to a package I guess is the question we're trying to ask.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Well a package would be assigned to any – so an EHR module was tested and certified to say, transitions of care, clinical information reconciliation incorporation, a couple – just say a couple of other capabilities, but so it could be labeled as a – care I think, if we just went to the – and to like the transport standard, right. So I think it can be labeled then to the care coordination package, which is just being able to meet the transition of care and – but you're – I mean, I think, and I'd have to go back and look at the care coordination, but I think – because we asked for comment on that one as to how – what capabilities should be included in that one. So, your question was whether or not it would have to be MU or not?

**Paul Eggerman – Businessman/Software Entrepreneur**

Well, would it be designated MU or not MU for the entire package or could you have a mixture of modules, some were MU and some were not?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Well, not within a package itself, because the package – I know the package – maybe the package isn't the greatest name, now that – because it seems like it's creating some confusion. So package only applies to one module, if I can say that, and maybe that'll help clear it up.

**Joseph M. Heyman, MD – Whittier IPA**

Well then – this is Joe. I thought at the last call we kind of all agreed that package was not a good term –

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Um hmm.

**Joseph M. Heyman, MD – Whittier IPA**

– and if package is the same thing as a module, why don't we just call it a module and leave the word package out of it altogether?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Well I think it's because a module can be anything from one criterion all the way up to every capab – criteria in a setting. So somebody could have a module that just does CPOE and then somebody has a module that does everything for that setting and one of them could have – obviously the one that could do everything for the setting would have “what we've defined as the patient engagement package and the care coordination package.” And then thus be labeled and marketed as meeting those packages.

**Joseph M. Heyman, MD – Whittier IPA**

But then it isn't the same as a module.

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

Yeah, I was assuming that module equaled one certification criteria.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

No. So an EHR module is anything certified to one criterion all the way up to every criterion for a setting. That was like the point I was trying to make about the complete EHR definition.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, so let me just actually apologize for asking that question.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

I don't – .as off topic.

**M**

(Indiscernible)

**Paul Egerman – Businessman/Software Entrepreneur**

So let us get back to the non-MU issue. It seems to me we're pretty close to a consensus on this, which is, I think people think this is – we want to applaud ONC for trying to make a step forward, we think it's a good thing to try. We have some concerns about how the marketplace will handle it and we don't – and we're uncertain about the impact, we can't really say a lot, about how effective it's going to be. Is that like a rough summary of where we are with this?

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

I think so, Paul.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

I think so.

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

Are there any other opinions among the workgroup members? Is there anything else we should be talking about on this issue, Jennie, or have we covered all the bullet points?

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

I think we've pretty much covered it. I think the last comment about, there are a lot of things that we don't know about how the market will respond, and I think that covers a variety of topics. So, I think that's it.

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

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

I think that's a – hopefully that's an important part to include in our summary, to just simply say, there are some questions but there's no way to answer that, about how the market will respond.

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

Yup. Good. Well let's move on to the next slide then, I think a different presenter. Who took on additional patient data collection?

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

This is Kate from ONC, I believe Mike took this topic on, but he was unsure at the last minute if he would be able to make the call, because he was called in for jury duty.

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

Oh.

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

So he's got some notes on some slides ahead if somebody else could lead it that would be great.

**Paul Egerman – Businessman/Software Entrepreneur**

I just have a question before we get started. It says the 2017 proposal; I don't understand why we're talking about – that's Stage 3. I don't understand why we're talking about Stage 3; shouldn't we be talking about the 2015 NPRM?

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

So, in the 2015 NPRM there were three sections; one section was talking about things that would be actionable and would show up in certification criteria as part of the 2015 edition; there were some questions that were leading into the 2017, so anticipating things that ONC might do, looking for early input.

**Paul Egerman – Businessman/Software Entrepreneur**

So these are questions in the 2015 edition that relate to the 2017 edition.

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

You got it. And then there was a third set of questions –

**Paul Egerman – Businessman/Software Entrepreneur**

I got it now.

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

– that relate to the certification program as a whole.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

This is Mike with ONC, just one clarification more for you. They are not actually 2017 edition proposals; they are Request for Comment to inform those proposals. So we haven't made any proposals yet for that "2017 edition."

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

So if nothing else, we should edit our slide so it shouldn't say proposal, it should say question – Request for Comment. Okay, so having clarified what it is we're looking at here, we're now jumping ahead as early input to the 2017 process and these were looking at, it says patient data collection, these are questions about the patient, this is not patient-generated data, correct?

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

Yes, that's correct.

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

So these are things that are typically under the demographics heading and –

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

Yup.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, although they frequently are answered like in an uptake form, I think that may be why you may have thought of it as patient-generated, patient's they give you a little clipboard and you –

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

All right. Sure. Thank you, Paul. And so these were things that are looking to be added to that and okay –

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

Paul, to be clear, there's a proposal whether or not they would be just included in demographics or whether or not they would be their own standalone criteria or a new grouping of criteria.

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

Ah, so that's the question, that's one of the questions in front of us, right, whether to treat these broadly as part of demographics, one criteria or individual.

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

Sure, I mean there's a baseline question of whether or not they should be included at all and then the method of inclusion.

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

And as I recall on terms of, I'll anticipate Paul Egerman's question, the recommendations from the Meaningful Use Workgroup were that these were certification only requirements to allow providers to collect more areas of information about patients to standards, but that they might not themselves be included in the MU objective.

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

Yes, this is Kate from ONC, that's correct. We don't have any indication at this point that they will be included in Meaningful Use, these specific – obviously there's a demographics related measure, but these specific criterion or data points would not be specifically called out.

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

Okay, and the way these slides are set up is the next several slides then have the com – the breakout on the questions, is that right?

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

Yes, that's correct.

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

So maybe we should go on to the next slide as a way to organize our comments. So overall this is saying that separating out each data group to different criteria doesn't make sense, to have one demographics criteria that would include these, but that – I guess there's been some discussion since we've reached a bar of minimal completion of demographics, would that be dropped altogether and if it was, what was the point.

**Paul Egerman – Businessman/Software Entrepreneur**

So do you want us to comment on that or do you want us to continue to go through this.

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

So I think these were high-level questions and then the rest are actually looking into the details of the individual items. So any thoughts about whether demographics should be broken out and these should be separately certified or whether this should all be part of one demographics –

**Paul Eggerman – Businessman/Software Entrepreneur**

See I have a comment that the SOGI stuff should be separated out and the reason is it just has to do with like security, privacy and security, because it's a little bit different than some of these other questions. And if you make it demographic data, a lot of these systems have role-based security, and if you make it demographic data, you're automatically defining how the security is going to work on that. And I just thought that at least for that one, if you separated it out and simply didn't specify where it was going to be, whether it's demographic data or else, where you left it up to the vendor. You could also create a greater amount of flexibility as to how they can handle like the privacy and security around those issues.

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

So I wonder if that's actually a good guideline for a lot of – right, that these are things that are useful information to collect, they could be used to address areas of disparity, they could be used to address areas of clinical services and other support services that might be needed. That lumping them under demographics actually might be constraining how they get implemented in ways that aren't helpful. And I suspect that some the disability things, people would have similar issues to, like I'm accommodated to my disability, I don't want it publicized, but it's important for my healthcare providers to have it.

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah. Well, here's another way to look at it is, what do you lose by giving the vendor that flexibility? I don't think you lose anything and it also could be beneficial for some vendors, who are maybe actually currently capturing that data, but they're not putting it in demographic data, they're putting it in some other place. I mean perhaps just saying it's demographics is too prescriptive, all you really want to say is you've got to capture the data.

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

My take is that gets to the essence of what the intention is here, is to be able to capture the data, and is to be able to use it to –

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah.

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

– segment populations, but it doesn't actually require that it be – that you have the ability to segment based on this.

**Paul Eggerman – Businessman/Software Entrepreneur**

Well again, I think what it says in the 2015 things is, it calls it demographic data. And one point, if I remember right, even talks about demographic package and I'm just saying, our recommendation should be capture the data, focus on the data and not focus on where it's stored, that that's overly prescriptive and could cause problems.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

So this is Jennie and I was just wondering about type of information to be captured and who and where and why, how it would be captured? When you look at those questions, it's – well, I'm assuming that really by 2017, the nurse will be using the Consolidated CDA, which have a whole series of data elements in it, including data elements on functional status and cognitive status and health condition including whether or not an individual's blind or deaf. Some of this content like does a person have difficulty doing errands or require assistance in doing errands, I don't think is a data element in the Consolidated CDA. So, I'm just – I'm a little confused as to what the source of this information is, what its relationship is to the content in the Consolidated CDA, how it would be used. I just had a series of questions about it.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, and my response is, because I was part of the Meaningful Use Workgroup where we went through all of this and the data has different purposes. So the SOGI data is really to address disparity kinds of things, is the – was the purpose. The purpose for the occupational information was, the way I understood it, was eventually to code it to be helpful with clinical decision support, which there were some questions raised about its usefulness. The – I forget the other ones – the military questions; I don't remember that that was part of the Meaningful Use discussion. And so there are different – what I'm trying to say is there were different reasons for it and I'm trying to answer at least one part of this thing at a higher level, which is to say, focus on the data, don't focus on where you're going to store it.

And then your question Jennie is a good one, there should be good reasons for collecting the data if you're going to require it. The other comment that came from Meaningful Use was there's also great value in ONC defining the vocabularies for these things, defining what is the data that you're going to store, if you ask the questions and we saw that as a great benefit.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

This I Mike with ONC, I just wanted to add on to that. In terms of our request, we made clear that the proposal was related to recording the data, and we asked for comment on – related to all these different data elements, whether or not it should be transmitted and how it would be transmitted, I think we even asked that. So, there shouldn't be just an assumption if you record it, it automatically goes into a Consolidated CDA and is sent on to somebody else, another provider.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, that's right.

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

I think there's a – to jump to a conclusion here. If you don't capture it, it's not available to include in the Consolidated CDA and if you do capture it, it would be great if the standards that were in place were consistent with what's in the Consolidated CDA so that the information actually could flow through.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Correct and therefore there should be some sort of alignment with what is in the Consolidated CDA, for example, in terms of vocabulary.

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

I believe if you go ahead to the next couple of slides, it'll get into a little bit more information on which vocabularies are used for which of those data points.

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

So before we leave this one, though, I think that I'm hearing a sense from the discussion that says, we want to focus on collecting the data, that tying it to demographics could actually create obstacles, either to vendors who already collect it or potentially to privacy issues or to workflow issues. Because there are all kinds of ways this information might be obtained and I think actually the presumption that you are filling out some kind of – you the patient are filling out some kind of form when you first show up and answering these questions, is actually a presumption. We don't know how providers might choose to implement these.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, that's right. I mean some of these things could just come from a patient having a conversation with the physician.

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

Yeah. Or it could be support staff who are asked to find out if the person has any problems acting on the plan that's been developed with the physician. And they might surface issues around disabilities or even an occupational thing, which I assume is as much about risk for disease, short-term or long-term –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah.

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

– as it is about anything in the immediate care process or immediate decision support.

**Paul Egerman – Businessman/Software Entrepreneur**

And on occupation, one of the things I didn't see, but if you're going to use occupation for that purpose, I think you've got to back like 10 years or something.

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

You've got to have – you can't just say current occupation, you've got to go back many years because, well –

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

Sure, if you were doing something with asbestos 20 years ago, you might not see the problems for another decade. If you were working with industrial chemicals, you might not see that problem for years as well.

**Paul Egerman – Businessman/Software Entrepreneur**

Or if you once worked with radiation –

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

– in an environment where there was radiation, a lot of examples.

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

Right. So I think you're right, making the information useful is going to be –

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

So, this is Mike with ONC, to try to turn that into a – because that seems like a very salient comment, into a – some type of comment back to us. And we're talking about EHR technology here, so we remember this isn't what you would be required to do for MU, should the EHR technology be able to capture then, multiple years of occupation and distinguish between years of occupation or is that too much of a – then as that gets to mu – like is it unworkable then? So I guess if you could just add on to your comment would be great.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, and my answer to that Mike is, yes it has to be multiple years in order to be useful. It's a separate question as to whether or not that's workable. In other words, when you look at the whole thing as the collective 10 or 20 years, and then trying to code it and the coding of it is – it's just very ambiguous how all these coding systems work for occupation and industry. I think when people look at the sum total on that one piece; they view it as an administrative burden. I just don't see how it's useful unless you have multiple years.

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

This almost feels like we're creating infrastructure, like we're saying having occupation, for example, is important, it affects people's long-term health. But it's not clear that there's enough experience right now to lay out a road map that says, we've got codes, we've got ways of structuring them so go ahead and put it into requirements, it may be much more high-level. Right, it's important to collect occupational codes, there's op – it could very well be a question about how well do the standard occupational codes support clinical actions, which presumably is why we're collecting these in the medical record. Or are there other aspects that might be more important. We were talking about the reason you want to know the occupation is to know exposure to certain things that might have long-term health effects. Maybe it's better to ask about exposure to those things and not worry about the industry.

**Paul Eggerman – Businessman/Software Entrepreneur**

Well, let's – so to try to respond to what Mike said. I think we already made a comment about being less prescriptive about demographics. On the occupation and industry group, I guess I'm suggesting that we make a statement that says, in order to be useful, you have to go back multiple years, I don't know what the right number is, say at least 10. You have to also account for the fact that people can have multiple jobs at the same time and then to also make a comment that we're questioning the administrative burden and the practicality of using that.

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

Right. So since we seem –

**Paul Eggerman – Businessman/Software Entrepreneur**

Without saying that it's good or bad, we just say we have questions about it, I think, would be as far as we could probably go in a conversation –

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

Maybe we should –

**Paul Eggerman – Businessman/Software Entrepreneur**

– there's a consensus around that –

**Joseph M. Heyman, MD – Whittier IPA**

This is Joe.

**Paul Eggerman – Businessman/Software Entrepreneur**

– but that would be my suggestion.

**Joseph M. Heyman, MD – Whittier IPA**

This is Joe. I just would say this, sometimes you don't get every drop of information when you're trying to take care of a patient, and we all have that reality. It's very helpful to know what the patient's current occupation is, that doesn't mean that it wouldn't be better if you know what her previous occupation was as well. But, to say that it isn't useful just having her current occupation I think is not true.

**Paul Eggerman – Businessman/Software Entrepreneur**

Okay.

**Joseph M. Heyman, MD – Whittier IPA**

So, I wouldn't say that – I wouldn't say something to the effect of, if you don't do this, then it's useless, because I don't think that's true. And I do think that many different EMR vendors have different ways of putting their occupations in there, and ways in which you can add extra information, for instance, you can free text it after you put in the template for their occupation. So for example, in my EMR there's a template you can choose the occupation, and then there's a little spot where you can put free text in. So my only concern is that we're becoming too proscriptive about the way this is going to look in the end and that's going to affect its usability, and its cost.

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

So how about if we skip ahead to slide 11, which lays out the occupational questions, and see if we've already covered everything that's on there. So, it sounds like you're looking – ONC is looking broadly for comments about this and I think we've given a whole bunch of them.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, if I'm reading that first thing correctly, after the first bullet, it does say occupation for each position linked and retained in perpetuity and time stamped. So this is like a resume.

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

Well, resumes get edited every time they're produced, so it's not like a resume.

**Paul Egerman – Businessman/Software Entrepreneur**

So, a resume should be or something.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

This is Carl; I'm back, by the way. It would be a good use for the new Blue Button feature, resume production Blue Button –

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

Wow, okay.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

There's a concept.

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

Sublime and ridiculous, we'll tie it to LinkedIn – I want my Blue Button to shift to LinkedIn, but just the occupational piece. And I also think here there are some comments about specific coding schemes, and in general, we've deferred that to the Standards Committee.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah.

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

Unless anyone has particular strong opinions about census codes versus SOC's versus other things.

**Paul Egerman – Businessman/Software Entrepreneur**

So getting back to our reaction to this, I guess what I'm trying to say is going back in perpetuity and coding it strikes me as administratively burdensome. And what Joe seems to be saying, well, if you give me less information, if I get something that can be very useful for me. So it seems like those are both good comments, because I mean people start capturing this stuff going forward and it becomes useful, more and more useful.

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

Yeah. And then over time it covers more time.

**Paul Egerman – Businessman/Software Entrepreneur**

I hope I said your views correctly, Joe, but that's what I heard.

**Joseph M. Heyman, MD – Whittier IPA**

Good enough for me.

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

Okay, maybe we should back up to some of the other things to make sure we've covered them, because I think we have. So let's go back to slide 7, so 7 is disability. So this was getting very specific about the questions that constitute disability and then asking whether these were the right questions or not. And I wonder if our overall comments about a high-level of it's useful to capture this information, not sure, as part of demographics is really the operational piece here. As well as the importance of the coding decisions be consistent across other ONC requirements.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

May I ask a question on this? This is Carl. On the disability itself, I can see where that would be standardized, on the if so, what assistance may you need? Is that anticipated to be standardized or free text? And if its free text, it will probably need to be maintained with the source organization because they may be able to offer patients things that other organizations can't offer them. We probably need to make sure that that remained at least metadata tagged with your originating organization and maybe duplicatively stored so that different organizations with different service level capabilities could articulate that differently.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Right and so I think along those same lines, and also to the first question on the slide, are these the right questions to ask, if the point – if part of the point of asking these questions is to find out whether or not someone with – someone has a disability and requires an accommodation. I'm wondering if the question could be significantly simplified and just ask do you require an accommodation when receiving health services or something along those lines? And if yes, you can have response options of yes, I'm visually impaired, b) I'm hearing impaired, c) whatever and then there could be a text portion where somebody could expand upon the type of accommodation that they need.

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

To our comments about, are we being overly prescriptive?

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah.

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

This particular structure here feels like it's very specific to however it was developed.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Right.

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

And it's easy to imagine other variants that might be more or less effective and so at least as a Certification and Adoption Workgroup, I think our comments about – that this – the intention here should be minimally burdensome, that where there are consistent coding that could be used, that they be available and used. But, I really feel we're getting into details of how care is delivered, that's probably out of scope.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

So just real quick, this is Mike with ONC, just to give you some context, if you haven't had an opportunity to read the rule on this. So those questions came from a survey, they're survey-based questions that are required under the ACA for surveys. And so the question was, can an EHR capture that information, and then it would be used just like I think Paul was mentioning earlier, different purposes; so in this case, the purpose would probably be for disparity reporting.

So I guess the question, if I was going to rephrase it, should EHRs be capturing that information as well as capturing more coded information related to disability. And I think it goes to what, I think, I don't know if it was Paul who said it or Carl, that it would be – could be source-specific in terms of these questions, how that particular provider could assist them when they came in for their doctor visit and so forth. So, I just wanted to give you context of where those questions came from, they were done by our, I think it's like our Office of Community Living, which is like for – they work with like specific populations.

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

So this is HHS Office of Community Living, not ONC.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Right. Yes.

**Paul Eggerman – Businessman/Software Entrepreneur**

And so – this is Paul. The way I look at it for the EHR, the EHR should be – what we should be focusing on is like recording the data and consistent standards of vocabularies about how the data is stored. But the EHR system really shouldn't be asking these questions of the patients, that's some other vehicle to gather that information. And the questions themselves might be considered like best practices or guidance, but there might be lots of different ways one could ask the questions, but the focus should not be on the questions, the focus should be on, well what's – for the EHR system, what's the data that's going to be stored? And what vocabulary standards do we have about storing that data?

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

So I guess – let me try restating Mike's comments, I'm not really directly commenting on Paul's reaction, but trying to figure out my own. So you're saying that there is a standard survey that HHS is going to be using, these are the questions that are in that standard survey. Does it make sense to bring these in to the healthcare setting and record them as part of the EHR?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Yeah, I mean, that's what we ask in the rule itself, if these are appropriate for capturing that information. And we also ask about disability and how it's captured in the Consolidated CDA and if that would be more appropriate in terms of coding and capturing disability.

**Joseph M. Heyman, MD – Whittier IPA**

This is Joe. I don't know how to say this in a nice way, but I'll try. We physicians feel like a lot of this stuff is for purposes other than actually treating the patient. Even a little thing like asking the patient's race or their ethnicity provokes a conversation at the front desk that takes time. And asking all this stuff to be put into an EMR puts the practice in the – I realize it may save money for some other aspect of the system. But it increases cost, it takes time and it's just another potential burden on a practice, especially the smaller ones that are trying to survive in spite of all of the pressure to consolidate. And there are a whole lot of patients who liked the idea of being in small practices rather than these huge networks. I just think there has to be some limit to what you expect an EMR and a physician's practice to be able to do. This seems to me that it's going beyond that limit.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

This is Marty from HRSA. Just because the information's in the EHR, does that mean that somebody has to capture it or is it just being included if you choose to enter that data?

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Yeah, so let me be clear – this is Mike with ONC. We, I don't want to say we regulate under the certification program that what gets certified. So this would just be for technology would get certified to this capability. As we tried to be as clear as we can in this discussion of this potential proposal and how it would be shaped, nothing is requiring recording – like MU hasn't proposed requiring this yet, to be recorded by a provider. So this would just go to the capability of the EHR technology and since I have the mic for this second, I wanted – I've heard that you don't want it in demographics, but should these all be separate? So if the technology came in, should they have to be able to do all these or should they – or could they get – could a technology get certified to be able to capture just disability information or just occupation information, if it so wanted to. So, gets back to our – what we've done with some other criteria of splitting out and giving more flexibility in terms of certification, because I just – all I've heard so far is not – shouldn't be part of demographics. But not whether or not these – we asked the specific question whether we should combine any of these or if they should all be like a separate certification criteria themselves as well.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

I think there's also one other issue from a developer's perspective and that is, if you have to have these to be certified, you'll have to make the choice to put them standardly in all your screens, at the risk of junking things up and having extraneous, unnecessary things for the doctor's office staff to deal with. Or do you somehow create optionality, in which case you've got to effectively communicate how do people turn them on and off at the appropriate time and moment. And if it's optional, are they optional as a block, are they all on or they compartmentalize, turn on the sexuality, gender identity, military status, but not turn on the occupational type things. Do you think that –

**Joseph M. Heyman, MD – Whittier IPA**

And this is Joe. I just –

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

– should require some thought and it will be a bit of a burden to folks, so it – to capture employment history at the level one would need to capture it in order to be useful, from the prior discussion, is really not insignificant work. You need to track that over time in a very comprehensive manner or it's just junk that you've collected.

**Joseph M. Heyman, MD – Whittier IPA**

And this is Joe, I just wanted to point out that he used the word, “yet,” Mike used the word “yet, y-e-t” when he said it was not covered by Meaningful Use “yet.”

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

Right, so it could be –

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

No, I wouldn't read that much into that, I just wanted to make clear, we're the only one who has a rule out right now, and we're the only ones that made any proposals or requested any comment. So that's –

**Joseph M. Heyman, MD – Whittier IPA**

Okay.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Just – don't read into that.

**Joseph M. Heyman, MD – Whittier IPA**

Okay.

**Elizabeth Chapman, MS – Program Analyst – Veterans Health Administration**

This is Elizabeth Chapman and I'm new to the committee, so perhaps I missed some earlier discussions. But I'm a little surprised to think of race and some other things like that as being not useful in terms of care and population health and that sort of thing, as there are certainly some conditions that are linked to those kind of characteristics.

**Joseph M. Heyman, MD – Whittier IPA**

Yeah, I'm not saying that they're not useful, I'm saying that at the front desk when you try to explain to somebody why, for example, the government would like to know whether they're Hispanic or not and then there's whole bunch of subsections, at least in my EMR for Hispanics. But if you're not Hispanic, we don't care, that starts a discussion and that discussion takes time and energy. I'm not saying that these things aren't useful, I'm just saying that there are other ways to collect that data instead of at the front desk in a physician's office.

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

Let me also put forward, its Larry, let me put out another thought about this. So when we talked about that this is a standard survey, it's almost like, in talking about patient-generated data, you want to say, well there is this standard survey that HHS has and it might be something that could be either brought in through user entry or loaded through some other means, into someone's medical record. And again, to our earlier comments about focusing on the data that it would be – I could very well be useful information to capture. And then it raises the question of, well, and then how actionable is it, right, the comments about the kinds of assistance one might need in the context of a practice might be more about the kind of assistance we can offer or the kind of resources we can direct you to if we don't offer the services ourselves. So I guess I'm feeling a little bit torn of some good intentions here, but I think getting them actionable is going to be really tough.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Well I'd certainly like to see the social and demographic data collected and I see a reason to keep it in an EHR, but whether somebody chooses to – and where to put is probably a concern, and whether somebody chooses to use it is their decision. Whether it crowds out certain screens is another story, but it certainly is valuable information.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

And part of the problem that I'm having though is that in the Consolidated CDA there already are data elements that could be captured that are right on point in terms of a person's ability to function both physically, mentally. And since those data elements are already available and also linked with Health IT vocabularies, why couldn't those data elements then be reused to support a variety of purposes, including possibly some – a survey or a request for accommodations or...I'm just not – again, I'm confused as to the intent.

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

So I guess what I'm hearing Jennie is that we have a potential mismatch between this standard survey that HHS is looking to use and the informatics work that's already been done in the Consolidated CDA to provide a vocabulary and a structure to capture this, or, not to capture it, but to communicate it across care settings.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

I think that's partially correct and generally speaking, in the Consolidated CDA, there are not these type of survey questions and these survey questions – I mean, it's – these are compound questions, which make it very difficult to code and that sort of thing. And so I just think – well, I'm confused about the purpose, if the purpose – and we've talked already in this conversation about potential multiple uses of this type of data. And so I think to – for me, anyway, to understand it I start with a single use, for example, figuring out whether or not somebody needs different types of accommodations when they go to a physician's office. And so then, what kind of information might be useful for that particular use? And then, there are other uses as well. And so, I just think – I think this is not clearly developed as a proposal, I think it needs to be parsed out more completely so that then, what are the best options for meeting a particular need can be identified. And in some cases, that's exactly right, Larry, you can look to available standards and available vocabularies to code information that may be needed to support a particular use.

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

Jennie, this is Kate, we certainly appreciate that feedback and we hope that if you guys have better formats or better questions to ask or ways to collect this information, that you comment with those as much as possible.

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

Well I think what we're suggesting here is that, and we can probably reference in specific what's in the Consolidated CDA as part of our response, to say these questions are one approach to collect disability information. But, the data standard that's in the Consolidated CDA isn't tied to specific questions and in fact, might not even be applied to these areas, so it's somewhat apples and oranges.

**Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology**

And Larry, this is Mike again, and you're – that's spot on in terms of apples and oranges. And I just want to – if you folks who haven't had a chance to read the preamble, we acknowledge that and we say that these questions for a different purpose, and as I mentioned earlier for the provider in that office setting, would it have some value? And so that's like page 156, if you have the display version and I can find the other page. But I just want to make clear that we do acknowledge there is a distinction between what you wou – the cognitive and functional status assessment and coding and these questions, so I just want people to have that reference point in terms of them thinking about, do these questions have value or not? Because a lot of discussion went into this before we even put it in the rule.

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

Sure. So, not to shirk a charge we've been given, but I sort of feel as a Certification and Adoption Workgroup, looking at certification criteria that our approach is more structural than content driven. And that maybe our comments really should be at that structural level and – we might not be the best ones to provide you the kind of feedback you're looking for. But I don't think we should improvise where it's really out of our expertise.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah but Larry, can't we – couldn't we also say something like, somehow including survey questions – I mean, the questions themselves posed by the EHR system and the answers recorded seems inconsistent. That seems like that's a policy statement you could make about certification.

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

Right, I mean we could talk about systems having the ability to embed a survey as a generic capability. And there could be lots of different kinds of surveys you might want to have your patients respond to. Is that what you're getting at Paul, or something else?

**Paul Egerman – Businessman/Software Entrepreneur**

I was getting at something else, I was saying that certification around survey questions that there was a – there might be a policy statement that says that that's not appropriate.

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

Oh, in terms of –

**Paul Egerman – Businessman/Software Entrepreneur**

That we should be focusing on data and the use of data and vocabularies and standards as opposed to certifying certification questions.

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

Um hmm.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Right, and on that point, perhaps looking at the reuse of data that can be captured in an EHR to – whether or not data can be reused to support various survey activities. So – and again, I'm not so sure about these questions that we're seeing on slide 7, I guess it is, but just as a general point of feedback, can – are – if a survey is needed can electronic health information captured in an EHR be reused to support a survey? And so if this is a survey questionnaire on accommodation, can you reuse the information in an EHR to provide information about an individual's need for accommodation? I'm very sympathetic to the need for that type of information, for somebody, even if they're trying to go to the small physician practice and they're in a wheelchair and they need to be able to get in the door and get up on the exam table. I'm very sympathetic to that, I'm just trying to make the – burden.

**Joseph M. Heyman, MD – Whittier IPA**

So this is Joe, that's a great use case example. I've never had a special place in my EMR for that information, but I do have an alert system and when a particular patient calls that does need that kind of assistance, an alert pops up, even when they're making the appointment, so that they can see that there's that particular issue about that particular patient. I guess my point is, I don't need to have that ability on every single patient, to have a place to put that in on every single patient, I can just write a free-hand alert that takes less time, takes less space in the EMR. I'm just – I just think that proscribing every single thing that has to be in an EMR makes it very, very difficult – I mean, it has to interfere with usability.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

I was going to comment as well – this is Carl, that these types of things for the purposes you mentioned, actually are commonly found in scheduling systems, because that's when you need to know how to best accommodate, different rooms, different staff assistants, etcetera, everything from translation services up to physical disabilities. The other thing I think you'd have to realize is that some of the disability statuses are temporary in nature, so it's not enough to just to find it out at a moment in time, it does often have a duration or sometimes it's permanent.

And I hear your words about Consolidated CDA, but I'm not certain that that should be a decision making factor. If data's captured in the EHR, its available for extract transfer, whatever one would want to do with it. But just because it's available, I'm not certain that would be the cause enough to try to force it into an EHR. Just because it could be transmitted with a C-CDA. Virtually anything can be transmitted with a consolidated – well, with a clinical document architecture, anything could be added, but I don't know if that automatically means it's a rationale to add it to an EHR.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

And I really appreciate your comment about the scheduling application, if you will, trying to figure out whether or not somebody needs an accommodation is something that should be figured out potentially before they walk in the door, or get through your door. And so therefore, before you have potentially even an opportunity to enter information into an EHR. So, I really appreciate that comment.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

And by the way, I'm not suggesting the scheduling system's fall under ONC certification technology, for the record.

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

Well I think, Carl, the relevant comment here is, there are many components to providing patient services and we should be sensitive to not being overly prescriptive about what does or doesn't go in the EHR. So I'm going to say we beat this one up pretty good and we've had a wide range of comments here and we probably can pull out of the transcript a fair amount of specifics. Why don't we, if we look ahead to slide 8, I think we've already pointed out that we're actually backing off from these proposals, right, that we're saying yes the disability information is important, but whether and how it gets collected, that this proposal seems too prescriptive.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Can I add one additional thought?

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

I love the misspelling of SNOMED.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

Yeah, yeah. I'm wondering if – notion of trying to capture the need for accommodations. I'm wondering if that should be – a recommendation could be take it to the S&I Framework and ask for some additional thinking about what is the purpose of capturing this disability information and if it's only with respect to accommodations, how are the different ways of communicating the need for different types of accommodation to different healthcare providers. I mean, the reason why I say that is, S&I has this public/private collaboration and there's an opportunity for a lot of input into that. And maybe a more – maybe another proposal could be advanced.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

I think they'll come back and just say yes, that's sort of what S&I Framework does, right. I think we want to make sure policy precedes standards in this case if we're going to create requirements for everybody. So, certainly believe that S&I could create value sets and standards and such, I don't know if that's – again, would that give rise to make it policy? I doubt it, I think we should consider in a policy perspective on its own merits.

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

So if we jump ahead and some of the comments Jennie's been making about Consolidated CDA sort of led me to this thought. So, the intention – there's been a lot of discussion about care plans and where care plans ought to be going and how to communicate care plans across settings, because they could become a powerful coordination tool. And in that context, accommodations for disabilities, the plans around disabilities are probably a very important part of someone's care. But that feels very different from all of the discussion we've been having today about data collection.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy**

But you know Larry, I – that's a really good comment that you just made and I think there is some additional work happening with respect to care plan. And I think making that as a recommendation to consider whether or not as a part of this standardized, shared care plan, if there's a need for – if an individual has a disability or a need for an accommodation, that the care plan reflect that. Which I think, just in terms of how the care plan document and sections were advanced through this last round of balloting, I think it would.

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

Okay, I'm going to suggest moving us along. I've heard a lot of discussion here, I think that our response really needs to try to tease out where we have policy statements that are important versus potential standards or issues around specific data elements. So why don't we go on to the next slide, which addresses gender identity and military service, an interesting combination for one slide. And these are – this slide 9 is laying out the questions that are in the NPRM and then slide 10 has some suggested responses. And my understanding on the sexual orientation and gender identity is that there is a Institute of Medicine Workgroup that's looking at better coding.

And I think our earlier discussions about segregating this potentially out of demographics is another example of the data is valuable, the context in which its collected is both important to the relationship of the individual to their provider. There might be issues of privacy around some of this and that to the earlier questions about separation, this is a good example of where the information probably should be separable. And I don't know enough about how military service information is collected to provide any comments on my own, but again, I think it's in some ways similar to the occupational code discussion we've had. It may put people at certain risk; it may enable certain benefit programs. And again, feels like a separable piece of the information that gets collection. Anyone got specific experience with either of these that would be relevant to our discussion?

**Paul Egerman – Businessman/Software Entrepreneur**

You're including the SOGI?

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

Yeah, I'm looking at both the SOGI and –

**Paul Egerman – Businessman/Software Entrepreneur**

I can tell you is what I've learned about SOGI is we're being smart if we don't try to comment about which code set to use. There's an interesting discussion and some controversies about that issue and it's important that ONC come up with something and there's issues about census data. But that should not be our issue. I'm with you on the military service, I don't know very much about it. I do know that there are some things, it just says whether or not somebody's exposed to war, but there's more than that in terms of understanding some healthcare risks. For example, they may have been in the Vietnam War, but if they were in the Vietnam War and they were exposed to Agent Orange, then there are some other healthcare risks. And so maybe this is enough to tell you something to ask those questions.

**Joseph M. Heyman, MD – Whittier IPA**

So this is Joe. Let me just – I don't want to beat a dead horse, but there are other ways to collect that, you don't necessarily have to collect it in a designated field within an EMR. And I just, that's all I want to say about it.

**Paul Egerman – Businessman/Software Entrepreneur**

Is that comment about military service?

**Joseph M. Heyman, MD – Whittier IPA**

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

By itself or is that also a comment about SOGI.

**Joseph M. Heyman, MD – Whittier IPA**

Well, I'm commenting about the military service because the first comment about the SOGI was we should keep our hands off it. But I would comment about all of it. I mean, physicians do know how to take a history –

**Paul Egerman – Businessman/Software Entrepreneur**

That's true.

**Joseph M. Heyman, MD – Whittier IPA**

– and they know what things are relevant and what things aren't and I just feel like we're getting so prescriptive here, just very prescriptive, that's all I'm saying.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

This is Carl, I was going to add one more comment, too. On the military service, in some of the work we've done with the DoD and others, they actually keep a fairly comprehensive record set on exposures. I wonder if rather than trying to recollect that data for servicemen and women, if we couldn't maybe find a way to get it electronically from the source, which I've been told is actually meticulously trying to track that for both disability and for management reasons. Second, on the gender identity, I know Facebook came out with a set of 50, I don't know what the background behind that is, but we might want to at least examine what else is going on out there with regard to capturing gender identities, or gender preference.

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

This is John Derr and I'm a retired Navy Captain with 31 years. And there – what Joe said is absolutely true and usually when somebody has a problem, they'll do it through the VA system and I know it's a little bit changing now because I was talking to the head of the VA and they're trying to use more of the community services. And I'm on this little group with ONC on rural medicine and that very support in critical access. So – but I think there are other ways to get that information and we don't need to collect it in what we're doing. But I do know most of what goes on there, if there is any need for it. But I would say we could interface with VistA or the DoD and get that information, or when somebody really needs care, it's already in the DoD or in the VistA, thing and they're going to a VA hospital or clinic.

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

Well – this is Larry. I really like the notion that this might be a place to look at interoperability and being able to get data from other systems, certainly at the policy level, this could be a great place for the civilian and military systems to touch each other. So maybe in terms of policy our comments ought to address that as well.

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

The only gap is, as Larry knows, I'm going up to work with the homeless Boston area, up in your area Joe and it is the homeless where we've sort of lost track of some of those people.

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

Hopefully the military knows when they're – though, maybe not where they are today.

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

Right.

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

Okay. Maybe we've put this to bed, we've – I think we've covered all the slides, not necessarily in order, but it's just about 5 of the hour and we should be going to public comment. So, are there any last thoughts from the workgroup before we do that? Okay, let's take this to public comment.

**Public Comment**

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

Operator, can you please open the lines?

**Rebecca Armendariz – Altarum Institute**

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press \*1. Or if you are listening via your telephone, you may press \*1 at this time to be entered into the queue. We do have a comment from David Tao.

**David Tao, MS, DSc – Technical Advisor – ICSA Labs**

Hi, thanks for the opportunity to comment. I just wanted to sort of second the earlier comments about considering whether the demographic data, what the purpose is. If it's secondary use that isn't really related to patient care, what is the cost versus the impact on providers, as Dr. Heyman mentioned, if they provoke discussions, waste time, that burden may not be worth the benefit that is derived, presumably, in analytics and things of that sort. So, I think that Dr. Heyman's comments were well considered and I just wanted to indicate that we should really think first about patient care and the other things should have lesser weight. Thank you.

**Rebecca Armendariz – Altarum Institute**

We have no further comment at this time.

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

I'd like to thank the workgroup, we've had a pretty robust discussion. It seems like this approach to getting the points out there to inform a robust summary and then we'll bring those summaries back to sort out where we've got some clear recommendations and where we just want to bring forward the discussion. So, we have another call in two days, let's see if we can be equally effective in getting through that agenda. Thanks again, everybody.