



HIT Policy Committee Certification/Adoption Workgroup Transcript May 22, 2014

Presentation

Operator

All lines are bridged.

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

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

Larry Wolf – Health IT Strategist – Kindred Healthcare

Here.

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

Hey, Larry. Carl Dvorak?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Here.

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

Hi, Carl. Donald Rucker?

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

Here.

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

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

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

Here.

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

Hi, Jennie. Joan Ash? John Derr? Joe Heyman? Kathryn Wetherby? Marc Probst? Marty Rice? Matthew Greene? Micky Tripathi? Mike Lardieri? Paul Egerman? Paul Tang? Stan Huff? Stephanie Klepacki? And from ONC, do we have Liz Palena-Hall?

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

Here.

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

Hi, Liz. And Elise Anthony?

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

Here.

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

Hi, Elise. Do we have anyone else from ONC on the line? Okay, with that, I'll turn it back to you, Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, let's go on to the agenda slide. I'd like to thank everybody who could make it this morning, it seems like we're, and I don't know what state of the world we're in, but I appreciate those who've shown up. We're going to look at three things today, really two things from our main discussion. We've got some public comments that came in both through the response of the blog and also during a listening session we held last week. So, we'll be going through those. And then we have the final chunk of recommendations for us to make to Policy Committee, and so we'll be going through those as well. And then finally there is a Policy Committee meeting next week – on June 10, not next week, the week after next. Next slide.

So, a quick reminder of what's happened recently. So back at the beginning of May, we made some recommendations to the Policy Committee and said we'd get back to them with a final round of recommendations at the end of this month, beginning of June. We posted a blog to get some more public input. We had a virtual hearing to get some additional input, I'm sorry; I should read things as they're posted. We had a certification hearing for two days live in DC, a lot of really good discussion. I know Paul Tang is planning to report on that at the Policy Committee. I haven't seen anything preliminary from Paul beyond what happened at that hearing, so I don't have anything new for the workgroup at this point. We had some – a work session and then a listening session, and today we're going to be reviewing the information that we got back from those and finally a recommendation. So, next slide.

Here are the folks who were at the listening session, we had a dozen presenters, quite a range of comments and I think almost all these were new to input to the committee. So it was pretty refreshing to have some new input as well as some blog comments were submitted. And we had, relatively speaking, pretty few comments, but those who commented had a lot to say. And so we'll be reviewing those comments and then we'll be discussing them. Then we'll be reviewing the input from the listening session and discussing that and then we'll go on to our recommendations. So, next slide.

I think this is just a quick recap, what we've already done. So, we made recommendations on transitions of care and privacy and security as part of a voluntary program, and those are really the core pieces. We asked the Tiger Team if they would look at issues related to the enhanced privacy and security needs of behavioral health, and so they've gone off looking at data segmentation and consent management. We asked the Quality Measures Workgroup to look at recommendations for these care settings, and they're also working on those things. And we talked about, at one of our earlier calls, the patient assessment instruments that are part of several of the post-acute – long-term post-acute care settings and so we have some recommendations on those coming out of the prior call. And then we'll be looking ahead at the "some providers."

So Carl was asking this question, so let me clarify for everybody. In our original discussions, we noticed that there are many different post-acute settings – long-term care and post-acute settings and that each of them have different regulatory requirements. They represent a whole range of patient acuity, of degrees of being residential versus ambulatory settings and so based on those different settings, a whole different host of functions might apply. And so we felt that there were a lot of certification criteria, identified functions that would be of value in some of the care settings, but typically not all the care settings. And we also felt like we didn't have either the time or the expertise to dial those in to exactly which functions went with which care setting.

And given the discussion that's happened over the last several months, I think really an emerging sense of the extent to which the certification criteria are being used in the Meaningful Use Program and that that program, that incentive program is driving a certain set of functional behavior and therefore system requirements. That we would really look to similar programmatic alignment that other HHS initiatives that addressed LTPAC and behavioral health might choose additional certification criteria based on the needs of those programs and how they aligned with the functional needs in the spaces. So we'll be talking about that today as well. Next slide.

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

Larry?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

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

If I could just ask a question on this slide, the Privacy & Security Tiger Team and they've gone off to look at data segmentation, consent management; do you know what their next steps will be?

Larry Wolf – Health IT Strategist – Kindred Healthcare

I know that they've been having a series of meetings and I'm expecting they'll be some recommendations from them at the Privacy Committee – I'm sorry, at the Policy Committee meeting coming up, but I'm not 100% certain of that. I did see a draft agenda, but I don't remember if they were on it.

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

Larry, this is Michelle. They did meet yesterday and so they will have some recommendations at the Policy Committee.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Great.

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

But, I don't know if we'll have all our answers then either.

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

Thank you very much.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, my sense from what they reported at the earlier Policy Committee is that this is very much an ongoing area of focus. And Michelle's right, they are on the agenda for June 10, specifically related to behavioral health issues.

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

Thank you.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Next slide. Okay, so what I'd like to do is go through these quickly, and Liz, do you mind. You and I haven't actually planned this, do you mind giving us the highlights off of these?

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

Sure.

Larry Wolf – Health IT Strategist – Kindred Healthcare

What I'd like – so, to give context for the workgroup and how I'd like to proceed. So, we did get in six responses to the blog and Liz has gone through and is summarizing those here. And I'd like us to go through the whole set of them, there are what, four or five slides?

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

Um hmm.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And then reflect back as a workgroup on the specifics people have commented on to us rather than try and take each one of these apart as we go through them. I think there are just too many here and we could easily get lost in a single one. So let's go through them all and then we'll cycle back with the workgroup for discussion.

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

Okay. So these were the general comments. There was a series of questions that were sort of overarching, and so this slide represents some of that general feedback. And so we generally heard that vendor effort would be significant, but achievable and the – there was also feedback around the time and effort that would be needed for workforce training and education related to certification and work – to adoption of EHR technology and workflow changes. Also that the admission process – if the admission process was – if some of the data from the admission process came for CCD data, it would reduce the number of fields that would be needed to be filled, which could result in time savings and reduced errors.

That some of the EMRs that are available today are having trouble consuming outside CCDs, but that commenters felt that this was a key capability. And that there was a need for clear directions on which modules were required to support various use cases. So the examples that were provided were for instance, interacting with – so the attendings who would be using these EHRs versus, for instance, behavioral health staff. Also noted was that today the ability for LTPAC vendors to receive a C-CDA is low. One vendor noted that they were only aware of one other LTPAC vendor that had this capability and that there is an ongoing challenge for using the Direct protocol to exchange C-CDAs across multiple states today. Do you want to move on to the next slide, Larry?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, let's –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Good questions, if we could – clarification on using across multiple states, I was curious about that. I just don't know if there's anything specific in the protocols that even make them aware of what state they're operating in.

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

So, just – I'll elaborate on the comment. So this was – this comment came from a provider that has facilities across states – that's the concept.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

– he's dealing with local – probably local HISPs in each state that demand they go through them.

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

Yeah, so I'm – the context, I think is that, yeah, that they have sites that are across state lines.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

The issue –

Larry Wolf – Health IT Strategist – Kindred Healthcare

So Carl –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

– I was going to say, that an issue that we have heard about is, if you operate one system but across six states, you might bump into situations where each of the state's demand that you use their state-sponsored HIE or state-sponsored services and pay for them. I have noticed that that's a point of frustration across the country where people run facilities in multiple states.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think the strength or weakness of the responses we got is that they often don't have the depth of exactly what's going on Carl, that would actually make this actionable, although I do think it does point to the fact that while in some ways the protocol is very straightforward, relatively speaking is straightforward, I guess. That there are lots of small glitches that may have to do with things like a state saying, we want everyone to use our HIE. Or could be issues of aligning provider directories or could be issues of just confusion about people haven't done a lot with Direct yet, and so they may also be thinking they have to negotiate individual accounts with individual organizations. So, I think there's a lot going on with this one, and I think we'll see some of that in the future slides as well. Okay, Liz, move on.

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

Okay, next slide. So there were a number of comments – so, you’ll see on these slides we tried to group them according to topic area. So this one is the comments that we received around care coordination and so generally, there was support for the provisions that support the ability to receive transitions of care and referral summaries. There’s also support for allowing patients and caregivers to access their medical records, to be an active partner in their management of their care. And specifically one commenter noted support for “a care coordination module.” So, this was described as – the module would meet the transitions of care and clinical information reconciliation functionality that’s in the certification criteria and incorporate those standards. And the module would also have the ability to transmit and receive data to support the goal. Are there any questions about this slide? Do you want me to just move on to the next slide, Larry?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, that would be great. If we have general discussion, we’ll do it at the end.

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

Okay. And so on this slide we have some comments around privacy and security. So, there’s been some – there were some ongoing comments I think from the previous hearing, there was a request for educational materials around the privacy and security criteria, and we heard that again through the blog comments. Also, commenters noted that privacy and security standards record any type of electronic record and are not burdensome.

There were comments on clinical reconciliation and that this data is key to care collaboration and critical for LTPAC physicians and ambulatory providers. And that there were – and there were some comments on managing lab test results and LTPAC ePrescribing. And so these are a little bit similar, I’ll start with the lab results. And the commenter noted the need to support 3-way messaging, so this is specific to the LTPAC facilities, so this is including labs, the nursing facilities attending physicians. And it was noted that developers would invent their own non-standard solutions without having a certification criteria built into their systems.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Quick question for you on privacy and security –

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

Go ahead.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

– for LTPAC I could agree with that its core to an electronic record and not burdensome, but on the behavioral health side, is that meant to include behavioral health there? Because that does have deeper considerations and also variation by state.

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

Yeah, so this – I’ll say this comment was made by an LTPAC commenter.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay. It might be worth noting that, I just – my sense from listening was that the behavioral health brings in a whole new dimension here that really probably does add some burden.

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

So this – just as a comment, this was in response to the – not the data segmentation consent management, but just the privacy and security certification criteria that are just part of MU today.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay.

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

Okay. And so, I'll just finish up the ePrescribing comment. So – and then there was a need for – to support the NCPDP 3-way ePrescribing use case, and this is also related to LTPAC – so this would be between the facility, the physician EHR and the pharmacy software. And the current standard of practice today is that the physicians and extenders initiate the patient orders over the phone. So the 3-way ePrescribing use case would replace that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, I'll jump in with a quick comment on that piece about orders over the phone –

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

Yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Because we're seeing increased presence of physicians and advanced nurse practitioners in the nursing centers on a regular basis. In the past it used to be they were very irregular visitors, they were required to be there once a month and they would typically show up more often than that, but not a lot. And we're now seeing, because of the higher acuity of patients and their much shorter stays that many physicians are choosing to provide some level of prescriber presence on a daily basis. And so in those cases, they're actually writing notes – writing orders like they would in a hospital setting, on an order sheet that originates at the facility and then is communicated to the pharmacy. So in many ways that three part relationship continues to exist, but two of the parts are now happening within a single setting, the – commentary on what's here. Okay, let's go on.

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

Next slide, please. Okay, so these were some comments on patient assessments, and there was support for standards that would establish crosscutting quality measures that could be initiated, I guess, from the patient assessments. And standardizing the data elements would be needed for shared clinical decision support between the facility and attending physicians. In terms of clinical decision support, commenters noted the uncertainty of pace between the CDS – CDS and eCQM alignment. And that would make developers reluctant to expend significant energy in this space.

Regarding patient engagement, commenters noted again that maintaining direct connections with multiple locations was beyond their administrative capacity and that today many of the providers resort to FAX messages because they can enter it once, they don't need the external support that's – in terms of engaging with a HISP. In terms of advanced directives, a supported documentation for advanced directives that used standard free-form text that corresponded with state's language. But the lack of a standard for advanced directives was noted, that would make the structural data elements difficult. And then there was – one commenter noted that the advanced directives should be included as an adult eCQM.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Liz, was there any clarification about why they felt Direct fit into patient engagement?

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

I think that was sort of related to probably V – view, download, and transmit.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

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

Yup.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thanks.

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

Why don't we move on to the next slide? Okay, so then there were some comments on data portability that this was not burdensome on the provider and it was basic consumer protection. In terms of immunizations, one vendor noted that passing certification was easy, but the complexity was that there are not many fully functional state systems. There were some comments on past medical history, particularly that it was reasonable to incorporate it in the Consolidated CDA, but requiring structured data might be intrusive and of minimal value. Another commenter noted that past hospitalizations would be a useful part of past medical history. And finally, there were some comments on DSM-5; particularly – the previous recommendation was that the DSM-5 be mapped to SNOMED. And one commenter noted that this should be changed to – that – to ICD-10-CM and that the DSM-5 codes are truly ICD-10-CM codes and that some of the codes – DSM-5 codes are not in the ICD-10-CM, which might result in billing errors.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So as Mike couldn't join the call today, but –

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

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

This seems to be bringing together some of the issues around the billing process versus the clinical documentation process and clearly you want those aligned but the fact we have different code sets in general –

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

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– potentially causes issues, and I guess that's what they're commenting on here.

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

Um hmm.

Larry Wolf – Health IT Strategist – Kindred Healthcare

They're looking to get people to get the billing codes right.

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

So, I think the next slide is for workgroup discussion.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, any overall comments from the workgroup on what we heard, or what the commenters said.

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

– Jennie, I just have a question going back to slide 8 on the clinical decision support comment.

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

Um hmm.

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

The uncertainty of the pace of clinical decision support and electronic clinical quality measure alignment will make it – will make developers reluctant to expend significant energy. I'm trying to understand really, what that means. Was there any additional information about that comment?

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

Umm, no, it was a brief comment but I – I mean I under – I think that there's just uncertainty about how these t – the – what the vision is and how these things will move forward. And so until there's more clarity – this was a vendor comment that the vendors wouldn't necessarily build to this clinical decision support.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Jennie, it's Larry; my sense is some of this revolves around who is doing the order entry in the post-acute settings and behavioral health settings as well and that if it's not the – and we've had this similar issue in the acute care setting. So if it's not the person who's actually originating the order and your systems aren't set up to engage that individual, then the decision support has a limited value. Because the person who wrote the order is not available to respond to the questions that are being asked by the decision support or by the guidance that's being offered by the decision support. And so I think a lot of implementations of this capability have really hinged on getting provider order entry so CPOE really is a precursor to clinical decision support. And that with that being something that's getting slow uptake in the post-acute settings, that it might, in fact, be problematic.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

That's –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead, Carl.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I'll just – right into this; I know we've experienced it. The quality measurement is very poor, from a vendor perspective, it's very poor and it changes a lot, so I'm suspecting that what this also is commenting on is it's hard to expend significant development energy on a target that's moving you just feel like you waste thousands of hours. So I wonder about the quality measurement aspect here, because the eQMs are very problematic and if I were a vendor without a lot of development resources, I wouldn't chase it, I'd let it settle out and figure out where it's going to land.

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

Yeah well –

Joe Heyman, MD – Whittier IPA

This is Joe, could you just tell me what an eQCM is, how is that different from a regular quality measurement?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Actually, not enough, the thesis was, we'll just electronify the quality measure definitions, but they put really chart abstraction quality definitions, tried to shove them into an XML format and it doesn't really change the game at all. So it's this notion of electronic quality measure definitions.

Joe Heyman, MD – Whittier IPA

Okay.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

But it still needs to change dramatically before it's truly easy to compute with the fire hose of events that happen in an EHR.

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

So thanks everybody for those comments and Larry especially thank you for the kind of insight into this...you thinking this is related to order entry – clinical decision support applications. And I think that that's an important clarification, I guess, because other types of clinical decision – I can see – I'm trying to understand what role, if any, and maybe that's also a comment here, either CMS or ONC has played in clinical decision support beyond order entry complications or even within that realm.

And so it seems – I'm not a vendor, of course, but it would just seem to me that at least silence in the area of clinical decision support could be an opportunity for vendors. But if there's a relationship between clinical decision support and quality measures or other regulatory priorities, for example, CPOE, I can understand wanting to get that settled in order for vendors to move forward in the – in that space. So, I don't know if there's a way to provide some clarification around this comment.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, so I think that rather than looking for clarification around the comment, because the commenter may or may not provide any further input to us, just raising these issues, I think, is useful. And Jennie, you were suggesting, and my understanding is that the current requirements for clinical decision support don't say they're tied to CPOE, they're up to the choice of the provider to choose areas that are important to them to bring in clinical decision support. So it could be used in many different settings and you might even argue that some of the guidance on the – in the MDS for care planning could qualify as clinical decision support.

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

Right.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

This is Carl, I rejoined, I had dropped for by accident there.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Welcome back. And I think to Joe's question about eQCMs, the intention but not the initial result, was that eQCMs would be derived from the data as entered in the record, without additional data collection or check boxes or any of the things that have in fact become major annoyances and workflow issues for people. And they point to the fact that, as Carl was saying, if you take measures that were intended to be created –

Joe Heyman, MD – Whittier IPA

On paper –

Larry Wolf – Health IT Strategist – Kindred Healthcare

– set up on paper or done through an abstractor who is reviewing the chart and just brute force push them into medical records, that you'd create all the kinds of chaos that we've seen, because they're not – they weren't set up that way. That by very definition they were asking for things that didn't necessarily fit cleanly into workflow, but were creating exclusions that you might not know until after the fact or might be completely separate from the decision process.

So, I think they've been one of those, we're going to try and get this right and my understanding is that we now have two de novo quality measures that are based on data in the chart for hyper and hypoglycemia. And that, I think, is where we're going to need to wind up is what are the things that are in the record that would constitute a quality measure without creating all this extra stuff. And I agree with Carl, it's something that's evolving relatively – well, I don't know how fast it's evolving, we'll have to see how fast it's evolving. We have two measures that are really de novo here and the quality measures in general in the post-acute space have been tweaked relatively often and so I could see where vendors coming into this new would be reluctant to take it on because it isn't stable.

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

Its Don, part of I think the regulatory challenge with clinical decision support, and I know obviously there were some good stabs at doing this in the prior Meaningful Use regulations, are that there's a lot of sort of probabilistic conditions if you're going to build rules in any kind of even one line expert systems. Because you can change the sensitivity and specificity of decision support from fires correctly 10 or 20% of the time, which is a huge nuisance, to fires correctly 70 or 80% of the time, which can be quite helpful. And I think putting that nuance into regulatory language is actually fairly challenging and so people tend to regulate more towards solutions that only fire correctly 10 or 20% of the time. It's a subtle point, but I think it gets at a lot of what the sticking point is in clinical decision support and the quality measures, of course, don't really get into that at all, because they're almost by definition binary at some level.

Joe Heyman, MD – Whittier IPA

This is Joe. Listening to all of this, it's one thing to prescribe a drug and have a pop-up say, hey, the patient's allergic to this or she's taking another drug that doesn't mix with this drug. But I think that if anything is coming out of this I would say it's not to emphasize clinical decision support as something that's absolutely necessary, in these – where there's no incentive program. And it's just something that's going to cause confusion, workflow problems and additional cost. Either I'm not on the line or everybody's just shocked at what I said.

Larry Wolf – Health IT Strategist – Kindred Healthcare

No, I think it's consistent with, a) what you've said before and b) I thought we sort of beat this one up.

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Are there any other comments from the various things from the work – any comments from the workgroup about the blog comments, before we move on to the listening session. Okay, well let's move on to the listening session. So, go ahead a couple of slides, please.

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

This is the first one.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you.

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

Yup. So there's – so there were a number of comments about broad issues of parsing CDAs and vendor compatibility issues. One of the HIEs noted that often times information gets lost in transit from the skilled nursing facility to the emergency department and that what they're doing is attaching PDF summary documents, including the interact form, med list and summary document, which is generated from their HIE and sending that through WebDirect. One of the home health panelists noted that EHR order entry tracking and electronic signature would be valuable to that setting.

That information sharing and patient data segmentation must be respected across for transitions of care and delegated for VDT for all treatment, payment and operations. And there was one comment around voluntary identity management, and this was suggested as an interim step until there's widespread data segmentation adoption. The example that was given was a patient that could be using MyHealthVet and they could select check boxes to determine what information they would want to go into their CCD file, and that that could be linked to their VDT output. That would allow the patient to decide what data's sent, but then in discussion, it was also noted that there's a risk of incomplete data being sent without a flag to the receiving provider.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Also I think this is one of those areas where on the surface it can be made to seem trivial, but as you get into it – that the kinds of things you can send in a CCD document go well beyond what a patient can comprehend they're screening out. So that the simple pattern of certain lab tests being done to check blood levels indicates that the patient has a problem that they're dealing with, so even if they knew to check the problem or to uncheck the problem, other things go. So I do worry that we're presuming that data segmentation is really even plausible as a method. With these comments, I didn't know if there was discussion around that during the listening session or not or these are just raw comments.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, actually Carl, there was discussion about that, you're not the only voice pointing out that there's tremendous overlap among the various indicators – among the various data areas. So if you said, don't send labs, but you sent drugs or don't send drugs but you send labs or don't send problem list but you send drugs and labs that an informed recipient would be able to reconstruct a pretty robust problem list, at least the things that were being managed. So, you're right, there are a lot of things. And if you let notes go through, the whole world of things –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

(Indiscernible)

Larry Wolf – Health IT Strategist – Kindred Healthcare

– could appear in a note.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think one of the things that's interesting, though, is the person who was talking about this notion of voluntary identity management in my mind seemed to be blending two concepts. And I think one of their concepts, which isn't here, which might actually be worth adding –

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

Um hmm.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– was, they were suggesting that patients could somehow segment how – what providers knew what about them by providing different IDs or different repositories. So they were suggesting that you might have two or three different email addresses and based on who you're interacting with, use a different email address. You might have two or three different credit cards and based on who you're interacting with, you might use a different credit card. And so people had the experience in their life of segmenting some of the information flow about them, and that that might be done in healthcare as well.

I don't know that I see how that becomes practical or actionable, but it got me thinking about what's often been discussed of voluntary national provider or national patient ID, that there could be a few organizations that stood up patient IDs and you could sign up with one of those. And you could use that ID consistently from provider to provider as a way to crosslink your information, so, my thinking is that there was a second intention here, but Liz is correct, the examples that the individual kept bringing forward were more like the selecting what information to be shared as in the example of MyHealtheVet.

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

So this is Jennie and I was wondering about the first bullet on this slide, broad issues of parsing CDAs.

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

Um hmm.

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

Was there any discussion about what those issues are?

Larry Wolf – Health IT Strategist – Kindred Healthcare

So there was some discussion during the listening session, in the Q&A part, and this comment came from an HIE and they said that while the CDAs generally could be accepted by a variety of EHRs, that they were seeing examples of particular vendors having issues accepting a CDA that other vendors could accept. And they didn't understand what about the XML was causing the problem, the HIE didn't understand what about XML that was causing the problem, whether it was something structural in the XML itself or whether it was something within the use of the standards for nomenclature that were being used,. It wasn't clear to them why there were issues with CDAs being received by particular vendors.

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

I'm wondering if this is something that could be remedied, perhaps, through refinement in some sort of testing protocol.

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

Hmm.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

This is Carl –

Larry Wolf – Health IT Strategist – Kindred Healthcare

I don't know, Carl, are you still on the line? Do you have any comments about the variety of CDAs that you guys are receiving and any insights into what make it more interchangeable?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

We do about a million and a half CDA exchanges per month and about a third of them are with non-EPIC organizations, about 10 different EMRs and about 60 different HIEs. And for the most part, they're pretty locked down. I wonder if their comment – what I have noticed is that some HIEs are trying to be more than just an HIE and trying to maintain repositories and do extra population management services. So I wouldn't be surprised if this is coming from an HIE that they're trying to require more than the standard and then giving a lot of variability in that. But from our experience and really half a million to non-EPIC sites each month, we're just not seeing a lot of variability. I think when people implement the standards; they're doing a good job of it generally.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So your thought is that it's one level down, it's not in the form of the document per se, but it's in the details of the sections that there might be data, like if they're trying to load labs, meds, or allergies.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Exactly. We bumped into – most HIEs want something more than standard because they're trying to create a business case to do some other function or service. And I think there's where we see a lot of variability in standards and what you would send to the New York HIE might be different than what you'd have to send to the Florida HIE, because of the extra.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And you can see that, I think, here in the next comment, too; one HIE attaches the PDF summary, there's just a lot of variability in HIEs right now.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right. Yeah, in fact I think they were – it was interesting to me that they were specifically using Direct as secure email and expecting a human being to receive the documents and make sense of them. And less about import into – less apart – take the document apart and parse it and more make it human readable for the receiver, and therefore were including PDAs of like the interact form, which is essentially a patient status summary at the point of discharge.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And it is tricky, a lot of the state HIEs in – particular wield a lot of power.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

So if you want, in most cases, states are holding the immunizations as hostage, so if you want immunizations, then you have to go to the state HIE. If you have to go to the state HIE you one, have to pay for it and two, you have to conform to all their extra bells and whistles over and above the national standard, and that's where we see the variability creeping in.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm. So some of this could be addressed through HIE governance, national HIE governance.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah, I'd be a strong vote yes for that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

But might not be a standards issue, as Jennie was suggesting, because they're in fact asking for different data. Potentially I guess standards, if there's optionality that could be nailed down. So Carl, when you're seeing that variability, are they asking just for this section is optional and we really want you to complete it or are they actually imposing custom information?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Both, in both, both of them Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thanks. Okay, let's go on to the next slide.

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

Okay, so then we heard that long-term care physicians and nursing facilities really share care for their patient concurrently, so this is beyond like transitions of care. And that orders need to be synchronized with the nursing facility EHR systems to be actionable. So the clinical documentation such as the MD note, history and physical need to be both in the MD EHR and the facility's EHR. There are also some comments about RxNorm, in particular that RxNorm was missing over the counter med information and that long-term care pharmacies are not ready for RxNorm.

There was a comment around that certification process has brought additional structure beyond the narrative notes for certified vendors and that allows for data analytics. That incorporating more behavioral health data into certification would be helpful. And one vendor on the panel noted that they had been certified to the 2011 edition and another vendor noted that they're considering the ONC 2011 and 2014-edition interoperability, the criteria for certification. And I think the next slide is a discus – is for

–

Larry Wolf – Health IT Strategist – Kindred Healthcare

It's just for discussion.

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

– tee up discussion, yup.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So why don't we back up to the other slide. Thanks.

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

The next one.

Larry Wolf – Health IT Strategist – Kindred Healthcare

The next one, yeah 12. So I think that this notion of physicians and nursing facilities as well as other LTPAC settings needing to share information during the care setting – during the time a patient is in that care setting is something that I'm hearing a lot about. Because various flavors of patient-centered medical home have existed in the past and certainly are getting more attention now. And so the physicians in that setting are very committed to maintaining records that they have access to over time that give them a good longitudinal view of what's happening with the patient as they move in and out of different care settings.

And so they very much want to have their notes in their record system, as they see the patient or as their partners see the patient in different care settings, but they're also an essential part of the provider – the facility provider's medical record. And so they also need to wind up in that system, and so I know of some examples where infor – where the narrative notes specifically are moved back and forth. And that works very well for that piece, as narrative, but other things like orders are much more complex, and we heard during the written comments that there were some 3-way protocols that NCPDP's developed for meds.

And they're relatively complex to get the coordination piece going right, and as anyone who's tried to get orders interfaced between labs and the nursing unit where the docs are writing the orders, for example, or pharmacies, that can become a very complex process. Outpatient lab orders being electronic I think is one of those stumbling blocks that we're going to continue to see for a while if you're doing anything more than saying, come pick up these labs that I've drawn and they're sitting waiting for your pickup. So, I think there is a real need for synchronization here, but I also think it's a really complex area. Does that align with other's experiences?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Oh yeah, the complexity's enormous there, especially when you look at the legal implications of what must be recorded in which records at what time.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

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

I think the idea of shared care across multiple clinicians and providers is certainly something that we've seen in many of the research projects that my office is sponsoring. Not just shared care between physicians and nursing homes, but physicians and home health agencies, nursing home residents and other clinical specialists that are involved in their care. So, I think shared care is really important for people who receive long-term post-acute care services, as well as persons with behavioral health needs.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And again, my – this is Larry. My experience is that that's – we have to figure out how to eat this element – elephant one bite at a time, because it's an area of huge complexity and it's also really important to address.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Larry, I apologize, but I need to drop off. The only comment I'll make on the recommendations, which I snuck ahead and read in the PDF document, were, I have a growing concern that we keep on billing behavioral health with long-term post-acute care. And I worry that one is very, very solvable, the long-term post-acute care I think is very solvable and could benefit society dramatically. But I worry about entangling with the behavioral health component, because I feel like that's going to be a nest of complexity that we don't come out of very well and if we do tackle it, we run the risk of messing up the other side of health care. So I would still make a suggestion that we try to bucket behavioral health to the side and tackle it independently, rather than continue to bundle it in with long-term post-acute that they really are just two different animals.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I think that that's really important to communicate, they are different animals. And, I guess on the other hand though, I think that we heard from behavioral health that they feel like in some context, in some settings that they very much are integrated with mainstream, so –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Oh, it's –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah, I don't want to diminish its importance, but I think it's a separate problem to be solved and it's going to take a lot of brainpower to solve it and I do worry that it complicates the other part of the problem that's more immediately solvable.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right, because you're looking at the privacy issues around that.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

In particular, yeah, right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I think that's actually an important point for us to communicate when we – and we should add that to the slides. Thanks.

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

Okay.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Thank you, I'm sorry to drop off –

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

It's Don; I think to Carl's point, part of what makes that difference is the really different sets and classes of providers who are – would be accessing an LTPAC record versus a behavioral health record. And we might want to just put that sub-point to sort of explain the distinction.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yup, I think that's important. I think they were grouped together more because they were two large sets of providers not included in the Meaningful Use Program. But they –

Joe Heyman, MD – Whittier IPA

I think, yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

They're different they're clearly very different.

Joe Heyman, MD – Whittier IPA

This is Joe; I think that the other point about it is just all the issues around segmentation.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Joe Heyman, MD – Whittier IPA

I mean there are different issues for an HIE from an EMR and I just think it's very, very complicated.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Great. Okay, so let's – so I'm going to assume we've wrapped up the listening session comments. Let's move on to our next section.

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

Larry, this is Jennie.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead.

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

In terms of again the comment about behavioral health and privacy and security issues, I think it may have already been noted, I'm not sure, but recognizing that SAMHSA is going to be holding a listening session on June 11 to solicit comments about 42 CFR Part 2, so that they can consider issues related to that. I think recognizing SAMHSAs interest in this area and looking towards whatever solutions they might be advancing, I think is something that should be taken into account.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, I think you're right and that's specific and to Carl and Don's points, Joe's points, these areas are very distinct and we've known that from the beginning, and we should just remind folks of that when we do our recommendations. So let's go on to the next slide. Okay, so we have one bit of – one bit more work to do. We'll be presenting some final recommendations, hopefully final, to the Policy Committee on June 10, addressing the third big bucket of recommendations that we had put together. So I think the next slide has our diagram, is that right? Yes.

So you may recall that we originally broke this up into three sections. We presented the top one, the red box one about all providers focusing on transitions of care and privacy and security. We made some comments about enhancements to privacy and security that we then asked the Privacy & Security Tiger Team to comment on, and so they're working on that. So that piece is done. We had an earlier discussion about the stuff in the green box, about setting-specific assessments and basically that comes down to that – or setting-specific needs that LTPAC has an existing set of assessment and there could be opportunity – definitely is opportunity to bring more standards to those assessments. And there also are some specific issues around certification and survey, not of the software, but of the facilities, that also raise access questions in those settings.

And that behavioral health had some specific needs, but they are very different, that there are not standardized assessments in behavioral health. Some states have some standards, but broadly speaking there's a huge diversity. And we've already talked about the consent issues and the privacy needs in that – for these settings, both the SAMHSA issues and broadly beyond SAMHSA. So what's left for us is what's in the blue box.

And we had originally; in the hearings we had way back, where we brought in panels of experts, reviewed many of these specific areas. And at this point, we're really looking, I think, for a broad policy statement about this variety of functionality and how it relates to certification. And so as you can see by looking at this list, there's quite a range here, from reconciliation activities to labs and imaging to quality measures to patient engagement to public health reporting. And in general – so maybe we should move on to the next slide. Yeah, thank you.

So, I think it what would be useful for the workgroup to sort out is some of the general policy statements we think are appropriate. And coming out of our last several discussions, going back now probably the last two months, was a real priority of we're looking for things to match what's in the – both the existing program, because we can really only comment on the 2014 things, because those are what's public. But in general that we're looking for certification criteria that are consistent for all providers and all vendors, and if you certify to a criteria, it's a known quantity.

And that that would then be consistent with the modular approach that you could choose these and continuing, like maybe it even should say modular and voluntary, we'll over-emphasize voluntary here, that the information – that the certification process at this point is voluntary. And to the discussion about where we chose not to get more specific, that the value of the functionality varied by care setting, based on the needs of the care setting, the scope of practice in the care setting, whether the patients were residential or not in the care setting so a variety of things that might affect the relevance of the functionality, but then why certification, right? And so I think our consistent message on certification is, it's valuable if it aligns to some other need.

So, if there are programmatic reasons, so in this case, I think actually we maybe even want to put in, HHS or CMS programmatic reasons. If there are policy initiatives that have funding or have regulatory requirements associated with them, where there's a need to say, and you have to have technology doing a piece of this, that having certification criteria for that technology makes sense so that everybody's clear what the baseline is, what the floor is. Not – and this is one of the problems we've seen again and again with the Meaningful Use Program is the regulations describe a floor, not a ceiling but often that those are seen as synonymous.

So really, this is about having a floor of functionality where certification would make sense. And that in general, we've had increasing disagreement, if you will, about certification outside of interoperability and privacy and security. And I know that at the hearings, there was a push for quality measures, and that's been less of an issue within this workgroup, but certainly those first two really have been the drivers that we've seen consistently. So, this is our last piece for discussion, so, comments from the workgroup. Wow, Liz, did you record that, can we just play that back for the Policy Committee?

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

Good summary.

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

Stunned everybody into silence.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. But Liz and I had joked we might be done early, maybe we're done early today. Any other comments? This is shocking. Michelle, would you open us up for public comment?

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

(Indiscernible)

Larry Wolf – Health IT Strategist – Kindred Healthcare

Am I right, that's where we are?

Public Comment

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

Yeah, I think that's where we are. Operator, can we 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 have no comment at this time.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well, I'd like to thank the workgroup members for today's participation, this is a great wrap-up of all the work we've done over the last several months. I remind folks that June 10 there will be a presentation, a summary of this presented to the Health IT Policy Committee as our recommendations in this area. So again, thank you and look forward to that final wrap-up with the Policy Committee.

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

Thank you and thank you Larry for your leadership of this group.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thanks.

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

Thank you, Larry. Bye, bye everyone.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Bye.