

**HIT Policy Committee  
Certification & Adoption Workgroup  
Transcript  
February 7, 2014**

**Presentation**

**Operator**

Lines bridged with the public.

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

Thank you, good morning everyone, this is a meeting of the Health IT Policy Committee's Meaningful, I'm sorry Certification and Adoption Workgroup. This is Michelle Consolazio with the Office of the National Coordinator. 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 will now take roll. Larry Wolf?

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

Here.

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

Marc Probst? Carl Dvorak? Donald Rucker? Liz Johnson?

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

Here.

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

Hi Liz. George Hripcsak? Jennie Harvell?

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

Here.

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

Hi Jennie. Joan Ash?

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

Here.

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

Hi John. Joe Heyman?

**Joe Heyman, MD – Whittier IPA**

Here.

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

Hi Joe. Maureen Boyle?

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

Here.

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

Hi Maureen. Mike Lardieri?

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

Here.

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

Hi Mike. Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Here.

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

Paul Tang? Stan Huff? And are there any ONC staff members on the line?

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

Liz Palena-Hall.

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

Jennifer Frazier.

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

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

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

Okay, well I'd like to welcome everybody today let's go onto the next slide please, our agenda slide. We've got a very full agenda and as you'll see we're nearing the end of what should be our review time for behavioral health. So, it's going to be – we're going to have to stay pretty focused. So, having said that let me give a quick overview of what's coming up next.

So, one of – so this group has a Subgroup of folks who have been working on workforce development and that group reported back to us and back to the Policy Committee about a year ago on sort of what ONC has done for workforce development and some thoughts about future directions that we'd like to see ONC and the government take in terms of encouraging workforce development.

And there is a specific opportunity coming up to provide input on workforce which is a every 10 year or so update to the Standard Occupational Codes that the Department of Labor takes on and the Workgroup has been, Subworkgroup has been focused on that and currently has some draft thoughts on defining an informatics job that, you know, lives in the space between traditional healthcare jobs and traditional IT jobs and we think it's an important category of things for the Department of Labor to be tracking and so they'll be bringing us information on March 6<sup>th</sup> looking to present at the March Policy Committee meeting.

So, folks getting what I'm talking about? This all make sense?

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

Yeah.

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

Great. Then we're going to get another piece, a patient perspective that we couldn't schedule into the hearing that we had a week or so ago and we'll be also having a bit of a dive into the requirements of 42 CFR Part 2 which defines the substance abuse privacy requirements and is an important part of behavioral health.

And a reminder in advance of that, that we're really looking here to understand current law and how that would apply to information exchange and how it would apply to certified EHR technology and try and stay out of the temptation to, you know, make tweaks to what the law is, this is to understand what the law is.

And then we'll be taking a review of what we heard at the behavioral health meeting very similar to what we did with LTPAC and review some next steps.

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

Larry, this is Mike, just on the 42 CFR Part 2 will there be a point in time other than today where we'll be able to discuss that in a little different degree so it's not just about what is current law but what are suggestions and possibilities down the road?

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

So, I'm happy to entertain that, I'm sort of trying to help us stay focused on what we could recommend to ONC and CMS as part of upcoming rulemaking around Stage 3 that they're telling us they're going to be taking on this summer and releasing towards the end of the year.

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

Okay, so –

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

So, I'm trying to work within that framework.

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

Yeah, I'd like to stay focused but there are some recommendations that might help along that line that I'd like to at least bring up.

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

Okay, okay.

**Paul Egerman – Businessman/Software Entrepreneur**

So, Larry, so this is Paul, so our recommendations are going to be related to Stage 3 of Meaningful Use when it comes to behavioral health as opposed to this sort of separate voluntary process that we talked about for LTPAC?

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

No, I think the time – it's more about timing Paul. ONC is playing the issue one set of rulemaking that's going to be the rulemaking that will cover Stage 3 and 2017 edition.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

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

And will cover the voluntary program.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

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

So, I was –

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, thank you for clarifying.

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

Thank you for pointing out short-hand is dangerous; it's about the timing of the next rulemaking.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, so we just want to be in synchronization with the timing.

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

As opposed to making a recommendation on what I'll call the "other stuff."

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

Right, yes, the simple answer is yes, the complicated answer is I suspect what we're going to hear about the privacy requirements around substance abuse information that that will affect receivers of that information outside of behavioral health because it talks about redisclosure. So, there may be some ripple.

**Paul Egerman – Businessman/Software Entrepreneur**

Thank you.

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

Let's get into it and see what develops. So, let's move onto the next slide. As a reminder we've had a very full year, end of last year beginning of this year.

We have this session and another one to specifically address behavioral health and then likely a pair of sessions to wrap up and prepare recommendations for the Policy Committee.

So, those who are used to our former Tiger Team members who are with us, I guess you understand about frequent meetings. So, let's go onto the next slide. Okay, let me hand this over to Mark.

**Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families**

Thank you, I'm Mark Savage I'm the Direct of Health IT Policy and Programs at the National Partnership for Women and Families, but I've been asked to start with a personal perspective on the issues before you and wanted to share a story.

A relative of mine who is in her 80s got pneumonia, she already had chronic obstructive pulmonary disorder and so she had to be hospitalized at Kaiser for several weeks. When she was released because she had been there for several weeks they needed to send her to a skilled nursing facility for physical therapy to get some of her muscle mass back and Kaiser dutifully issued the hospital discharge instructions but she went to the skilled nursing facility late on Friday and so the hospital discharge instructions were in an envelope someplace, weren't entered into the facility system.

Now my relative is bipolar, she has been taking lithium for many years. She was also taking Ativan for anxiety and she told them, late Friday night, that they needed to give her anxiety medicine and they weren't sure precisely what to give her, how much to give her because they couldn't find the discharge instructions.

And what ended up happening was the relative asked them to call us at home and we got a call at 2:00 o'clock in the morning, fortunately we were home, fortunately we knew what her medication was and we were able to talk with the nurse that called us and to say "yes, this relative does know what she's talking about, she does need the Ativan and she will know exactly how much she needs to take so please listen to her."

And I mention this personal example because I think there are a couple of lessons in it, probably obvious to all of us, but worth lifting up again. First is that the healthcare sphere that we're working with reaches more widely than just the Meaningful Use Program. There are other parts such as behavioral health and skilled nursing facilities that really are a part of what we need to be thinking about even if they're not within the Meaningful Use pool.

The second is the lesson of the importance of exchange with unaffiliated providers, the skilled nursing facility was not affiliated with Kaiser so, you know, Kaiser has a fairly well developed EHR system but there was no electronic exchange of those hospital discharge instructions that could have precluded this problem.

And the third lesson here, which should be obvious to all of us, is the importance of family caregivers and the need for care plans and care planning that includes family caregivers in the ambient so that we are all knowledgeable, we're all able to participate.

So, with that personal story I was asked to shift, to share some ideas that the National Partnership and the Consumer Partnership for eHealth have been working on around care planning that would embrace behavioral health needs and other needs as well.

The Consumer Partnership for eHealth is about 50 consumer patient and labor organizations and recognizing the shift in Stage 1, 2 and 3 of the Meaningful Use Program we asked them, and these are across the states, different walks of life, we asked them what they thought patients needed and caregivers needed from health and care planning tools in an electronic environment.

And I understand that the result of that work the care plans 2.0 has been made available to the Workgroup for you to look at later so I'm not going to go into all the details I'm just going to, in the interest of time, just going to address some of the big picture points there.

What the Consumer Partnership for eHealth told us was that capturing the information about a person's goals for health and care is a foundational step developing a comprehensive shared care plan. So, it's not just the doctor's goals but it is the patients and the caregiver's goals as well.

You may have a situation where the patient doesn't really understand it from the doctor's clinical goals but if you restructure it as the patient's goal, so for example, I really would like to be able to attend my daughter's wedding and to be able to walk down the aisle, that may be the motivating goal rather than some clinical goal as articulated by the doctor.

Second foundational point that the Consumer Partnership identified is that the care planning process should identify and communicate values and preferences and goals for all care. So, it's not just the particular episode that might be captured in a transition of care for an episodic moment of treatment, but rather looking more broadly at health and wellness planning as well to sort of fit the care planning, the individual episodic care planning into the broader perspective.

And the third foundational building block that they identified is that care plans must incorporate the different cultural and linguistic preferences and the literacy of the diverse patient populations and caregiver communities in order to be effective. So, this is really essential for the patient to be able to express an informed preference or goal.

So, with those sort of as building blocks everybody in the Consumer Partnership identified five core principles for health and care planning. First that care plans should be goal oriented dynamic tools not just static documents.

Second, that they should – that the tools that facilitate care planning should enable all members of the care team to securely access and contribute information according to their roles. So, in my personal example of course that would reach us because we had the information that the skilled nursing facility needed.

Third, care plans should identify and reflect the ability and readiness of an individual and caregiver to successfully meet their goals as well as potential barriers. We're not all – don't all have the same skills, the same understanding so that the care plan should reflect that in helping to identify who is going to handle what piece of the plan.

Fourth, care planning and tools should facilitate decision making and specify accountability. And lastly, the thought that truly every individual would benefit from health and care planning and tools because across all different stages of our lives, across all different issues in our lives we are planning for our health and care.

So, you'll find in the document that was circulated a much more detailed explication of those five principles but I think, and we think that those principles for health and care planning will serve well in the larger Meaningful Use context and especially as my personal example shows in the behavioral health context and it would be our hope that in Stage 3 even that we can do more than we currently are to build health and care planning into that stage. And with that I'll turn it back to you.

**Joe Heyman, MD – Whittier IPA**

This is Joe Heyman. Mark I think you left out a very important fourth principle from your story and that is that people have to give a damn and the fact of the matter is you can have all of the technology in the world that does all of the things, the five things, that you've just suggested, but if people don't give a damn nothing happens.

And Eva Powell and I Co-Chaired a paper from the eHealth Initiative about coordination of care and we made that point in the paper as well because there was nothing stopping the nursing home when they realized that they didn't have the information they needed from calling Kaiser and asking for the information. Instead your mother had to or whoever she was had to make an issue out of it until they finally called you at 2:00 o'clock in the morning when they could have called Kaiser at 5:00 o'clock in the afternoon on Friday.

So, I just bring this up because technology cannot fix everything and human beings have to be caring and I think this was an example, for me, the biggest example here is that nobody cared enough to make an issue out of it and to actually make the call.

**Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families**

Thank you for that and to tag onto that it is the family caregivers who are most likely to give a damn and that's another good reason for making sure that they are definitely incorporated.

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul Egerman, I wanted to add a comment, I think Joe's observation is excellent, but what happens a lot, at least in the Boston area and I think happens in other places too, that Kaiser could have done is that a lot of acute care facilities will simply give sort of like read access to their records to the extended care facilities in the region so that, you know, if, as Joe says, that people give a damn they can actually look it up and it requires an organization like Kaiser to be willing to not just transmit data but to make data available and that can be very helpful in these care facilities, because it's not just medications there maybe issues about like diets and notes –

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

Paul, I'm sorry, this is Michelle, it's really hard to hear you.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, well, I was just simply saying there is another solution which Kaiser could simply make – give the SNF read access to their data, that's actually a very simple solution to this problem.

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

Larry, I was going to say, one of the things that's happening with Stage 2 is that – and Larry and I have been working on this, is that most of the care providers that go beyond our hospitals we can send lots of information like what was needed in this situation through either an HIE or Direct and so what we discovered that was that none of those places had any Direct addresses and so what we're doing, because I agree with you Paul, is we are providing those e-mails for them so that they would have all the medications, they would have a summary of care, they would have the discharge instructions electronically and all we have to do is, you know – obviously we have to have a place where they can access it, which is the same thing that Paul's saying whether you go in through a – directly into the EHR inside of the acute care setting or whether we send you that information being held electronically.

I mean, I'm hoping that Stage 2 is going to help but I don't think it's going to solve it and I can tell you, I think we may have touched on this last time, when we surveyed, in 23 states all the places that we work with, the ability of those nursing homes, behavioral health, home health, assisted living to have Direct addresses they didn't have them.

So – but if we can help as we move forward to make that, you know, part of the temporary or part of the voluntary certification on both sides we won't solve everything but it will be a big step in the right direction.

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

This is Jennie Harvell, and I wanted to thank Mark and the other Workgroup members for their comments. I think the story that Mark shared describes the importance of timely exchange of information as well as describing the importance of shared care planning which exists, there is a need for that whether an individual is transitioning from one setting to another or receiving continuous care for example in a skilled nursing facility because multiple providers will likely be involved in the care for that person during that single episode.

I think Mark's story also – is not only engaging family members on behalf of persons with various mental health conditions but I think it also suggests the need for timely exchange of information and transitions of care and shared care planning involving family members for persons with cognitive, various types of cognitive impairment including Alzheimer's disease.

I also wanted to mention that the Standards Interoperability Longitudinal Coordination of Care Workgroup has made recommendations to the Meaningful Use Workgroup of this Policy Committee regarding the importance of shared care planning and has worked with HL7 to advance standards to support the interoperable exchange of such care plans and the S&I –

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

Sorry, we're getting a lot of feedback if you aren't speaking if you could please mute your lines it would be appreciated.

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

Thank you. The S&I LCC Workgroup recommended the adoption of the standards through the Consolidated CDA to support the exchange and development of these shared care plans across team members.

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

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

Mark, this is John Derr, Mark Savage?

**Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families**

Hello.

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

Well, I don't – I don't know if I didn't hear it and I know I'm on the Patient Engagement Workgroup and also on the S&I Longitudinal Care and we've been, not very aggressively, but we've been trying to introduce quality of life into the advance directive. So if you aren't looking at that area you might look at that because I think as time goes by instead of just having in the advance directives turn on or off different pieces of equipment that we can put in there what a quality of life is for that person or what they want it to be and that quality of care would bring them back to that quality of life or they would be given a different level of quality of life and I guess since I live in the State of Washington if we don't like that quality of life that we're going to have to have we have the opportunity to check out.

**Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families**

This is Mark, thank you for that observation, we have been looking at advance directives and indeed it's why we sort of broadened to care planning in general because you can have conditions or illnesses across the stages of life that might warrant an advance directive and it got us to thinking about a broader care planning process that would encompass those range of life situations. So, thank you for that.

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

I also made a – I also made a suggestion Doug Fridsma and some others on another group call I was on that – and I just suggest this to the group sort of one of my windmills, but we don't – there was a case study on one of the other calls I was on where a lady was admitted to a hospital and they asked where is your advance directive and she said "it's in my safety deposit box in the bank" and we commented what good is it going to do us if it's there and where we put that – maybe it's in the EHR.

But I also recommended a thought that we might have the pharmacist, who is a professional, which I am one, and they aren't as included in this whole spectrum of care and they see the patient probably more than anyone else does in the profession and they have a great computer system and they might be the retainer of the advance directives.

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

This is Larry I want to jump back in for a second and respond to some of the comments about what people are doing today building on the existing technology that's in place, you know, Paul and Joe's statements about contacting the sending organization and maybe even having user accounts on their EHR or what Liz described with use of Direct and setting up Direct accounts for downstream providers and hosting that service for them are two examples of how the existing infrastructure, whoever houses it, can be leveraged to provide access to these other care settings.

But in those examples we're really taking people out of their workflow and to have our phrase of the day requires them to even be of more of a damn to find that user ID and password for a system that they may not be using every day and to actually be able to receive it into a system that's integrated into the work they're doing really improves the odds of the information being used.

And I think the example of the packet of information getting lost is, you know, an example of people are alert for those packets and even they get lost and so accessing other provider's systems can be of huge value and I know some examples where it is of high value where there is a primary referral source that a lot of the patients are coming from but where it's relatively infrequent it really becomes even more problematic.

**Joe Heyman, MD – Whittier IPA**

And this is Joe Heyman, I just want to emphasize that no matter what system you develop if people don't care it's not going to work because it can never work completely perfectly.

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

So, this is Liz its 10:30 I just want to do a time check to make sure we continue on because we've got a pretty packed agenda.

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

So, thank you for jumping in Liz you're reading my mind.

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

Okay.

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

I want to thank Mark for his input to us and for the documentation for some of the comments. I'm glad the folks on the call clearly give a damn you made it to the call this morning, so thank you for that and let's move onto learning about 42 CRF some more.

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

Okay, thanks Larry.

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

So, I think we need to skip ahead a couple of slides actually.

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

That's the one. Actually, is this the right deck? We should be on –

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

Back up, sorry, my deck had a filler slide we didn't need.

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

So, the next one should be it.

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

That's where we want to start.

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

Yes, okay. So, this is Maureen Boyle from SAMHSA I lead the Health IT Team in the Center for Substance Abuse Treatment and we heard a lot of testimony during the hearing related to the substance abuse confidentiality regulations 42 CFR Part 2 including the need for consent management from things like standards for communicating consent policies, to electronic signatures.

We also heard about some issues around consent requirements including the need to name specific providers or provider organizations and the consents and how that is presenting a barrier to health information exchange.

We heard about standards for communicating consent policy obligations to the receiver and potentially developing standards for controlling the redisclosure of information in order to comply with the regulations.

And we heard support for granular data segmentation that would help support compliance with various state and federal regulations although within that context it was acknowledged that the field isn't ready for that level of granular data segmentation although there are pilot tests that are ongoing.

So, kind of given everything that we've heard I kind of wanted to give a little bit of additional background on 42 CRF Part 2 to just try and frame things a little bit more. Next slide.

And, you know, as Larry said what we're trying to do is to frame the discussion around compliance with the existing regulations using technology. So, the – you know, SAMHSA is – SAMHSA owns the 42 CRF Part 2 Regulation and so we have – you know, we're deeply aware of the issues that stakeholders are having with Part 2 and the challenges that are being posed within the new, you know, Health IT related infrastructure that's been and is being developed.

And SAMHSA has been looking at the regulations in that context, but this isn't the appropriate venue to, you know, to make policy suggestions for SAMHSA. This is, you know, this venue is about making recommendations to ONC and CMS who don't kind of have authority over the regulations.

And so what we're trying to do is to look at this in the context of, you know, given that these regulations are likely to persist at least in the short range, because it takes years to amend regulations, that, you know, we're looking at how we can comply with the regulations as they currently are.

So, basically these regulations both 42 CRF Part 2 and we heard during the testimony that about half of states have confidentiality laws around protecting sensitive behavioral health information in addition to laws that protect things like HIV, genetic information, reproductive health and many of these require or most of these require patient consent to share information and many have prohibitions on the redisclosure of that information without consent. Next slide.

So, 42 CRF Part 2 was developed to encourage patients to seek substance abuse treatment without the fear that by doing so that their privacy would be compromised. Next slide.

And basically, these regulations state that with limited exceptions patient consent has to be obtained before sharing information that comes from a substance abuse treatment facility that is subject to Part 2.

And a disclosure is basically any information that identifies a patient as being a substance abuse – as having substance abuse issues and having received substance abuse care at that facility, so, even acknowledging that a patient is or was at that facility is a breach of the regulations. Next slide.

And we did hear a lot in the testimony about the issues with the consent requirements for Part 2. So, there are nine required elements of a Part 2 consent form and the most controversial of which has been the number two here which is the consent form has to give the name or a title of the individual or the name of the organization to which the disclosure is to be made and this has been posing some issues for organizations like health information exchange organizations and coordinated care organizations that have a fluctuating membership of providers because those consents have to be updated to include the new providers in those contexts and, you know, while this is technically very feasible most EHR systems and HIE systems haven't incorporated this type of technology to this point. Next slide.

And another thing that is associated with the regulations is that each disclosure made from a Part 2 program has to be accompanied by this notice on the prohibition of redisclosure which basically says that the federal regulations prohibit the receiver from making any further disclosures of the information without consent. Next slide.

And as I mentioned before there are limited exceptions to the disclosure without consent or to the consent requirements. So, in the cases of medical emergencies, which we refer to as "break-the-glass" you know patient consent isn't required in that instance and the same thing for things like child abuse reporting, crimes on the premises of a program, research, audit and evaluation and then there is also the possibility of creating a qualified service organization agreement which is basically equivalent to the HIPAA or somewhat equivalent to the HIPAA business associate agreement where they can share information without consent when there is a qualified service organization agreement in place for them to share information related to that organization providing services. Next slide.

And here is just some of the language around the medical emergencies provision. So, a medical provider can make the determination that they need the patient's Part 2 information because not having that information poses an immediate threat to the health of the individual and that they require immediate medical intervention.

The regulations do also have additional requirements that the Part 2 Program has to document this disclosure, you know, naming the individual who has made that decision and also some other details of the disclosure. Next slide.

And I just wanted to point the committee to a couple of sets of frequently asked questions that SAMHSA has developed around 42 CRF Part 2 as well as some webinars by the Legal Action Center in case anybody wants to get into more nitty-gritty detail on this. Next slide.

And as I mentioned, you know, state laws also provide additional protection. So, this isn't simply an issue of 42 CRF Part 2 there are many laws for which the type of functionality that we're talking about is going to be necessary and what will be important is that EHR systems have the ability to cope with this variability and state regulations and statutes. Next slide.

So, the two things that SAMHSA sees as the highest priority elements to ensure that the system can comply with 42 CRF Part 2 and other similar regulations is that one that we have standards for communicating the obligations associated with receiving protected information and as we mentioned on the last – on one of the previous calls, there are the HL7 privacy and security classification system which was initially developed under the data segmentation for privacy initiatives, so it's one of the elements of the standards that were developed and piloted through that initiative, basically do that, it has metadata tagging codes for, you know, for marking a record as, you know, being subject to additional protections and things like, you know, purpose of use codes, prohibition on redisclosure type of codes.

And basically what we would need in that context is twofold, one the receiver needs to be able to process and comply with those codes and within the behavioral health settings as well as any settings that collect protected information where they would need this type of – where when they're sending records that has privacy obligations associated with it those organizations would need to be able to apply the codes to the documents that they're sharing.

And then secondly, you know, these organizations that are receiving information that is subject to these additional protections need to be able to comply with those obligations including the prohibition on redisclosure and this can be done through – so there was some confusion after the last call around data segmentation because I think some people equate a data silo with data segmentation and what SAMHSA is trying to get across is that while this could be done with kind of metadata tagging and granular data segmentation this could also be done with, you know, data siloing.

So, information comes in that's protected and it's put in a separate part of the EHR that just never gets shared, which obviously is not an ideal solution. We would love to get to a place where people are doing more granular data segmentation and they can fully integrate the information that they receive from a Part 2 program into a record and, you know, maintain the metadata so that their systems can prevent it from being shared unless there is a consent in place. But we recognize that most systems aren't at a place where they're able to do that at this point.

And we think the most important thing is that we get to a place where these systems can, you know, in whatever way we can, can accept Part 2 information and comply with the regulations. And so, you know, having some sort of standard around, you know, the ability to control redisclosure in whatever way that looks like and basically that's it. So, any questions around this?

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

So, Maureen, this is Jennie Harvell and so thank you very much for this summary of this area that every time we talk about it I learn a little bit more and still have a lot of questions about, but, so thank you for your information today.

And so it sounds like, and – it sounds like, at this time, there are some standards available that would help communicate to a receiver of certain types of information that this information is sensitive and is subject to these particular privacy protections that's one.

And then two, standards that would communicate to that receiver what additional protections, policy protections are needed in terms of redisclosure is that –

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

Exactly, yes.

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

Okay.

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

This is Mike and maybe Maureen you can talk about that, because to my understanding there are standards that will say something is highly sensitive. There is no standard that says it's 42 CRF Part 2 sensitive and that doesn't get stuck anywhere on the document.

So, I'm not under the understanding that there is anything that says this is 42 CRF Part 2 sensitivity it just says there are sensitive – this document is sensitive or this data coming through is sensitive and it doesn't get to the area of 42 CRF Part 2, I've never heard of that one yet.

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

So, actually, I believe that there are specific codes that call out 42 CRF Part 2. Part of the difficulty though is kind of where codes are put. So, if – so, you know, I think typically the way that this work is on like the outer envelope it basically says restricted, so, you know, like an “R” for restricted letting the organization know that some of the information within there are subject to additional privacy protections and this – I am not exceptionally well versed in this, but we can bring somebody on who is, and that there are other codes where you can explicitly say that it's Part 2 and there are kind of policy obligation codes with things like “no reuse” or “no redisclosure” or “purpose of use limited to treatment” that type of thing that can get to all of the kind of detailed obligations associated with Part 2.

But they do need things to be set up such that, you know, you wouldn't be able to tell – that somebody who is not authorized to know that there is Part 2 information in there wouldn't have access to that simply by having access to kind of the, you know, the envelope if that makes sense.

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

**Yeah it makes sense, but I don't – I think we need to have that expert come in because, you know, with all the HIEs we've worked with nobody knows those codes. There is no HIE that I've talked to so far that anybody says “oh, good I could use those codes.” And, you know, I talk to them all the time about this issue because it's a major issue.**

So, I think we need to get somebody to come in and say these are the codes this is where they go, because other than that nobody across the country knows what they are. Other sensitivity codes, yeah, I certainly agree that they are there.

So, I think we need to get to that level and then promulgate that information to folks so that they can stick it on their document, they're not going to necessarily be able to stick it on the discrete data but at least they could stick it on the document so the document doesn't flow any further.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and this is Paul –

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

So –

**Paul Egerman – Businessman/Software Entrepreneur**

This is Paul I also want to make the observation you need more than just the codes to make this work, you need the software that actually does something with the codes and the way I understand the state of the art right now it's sort of like all or nothing, you know, it's like you either transmit the data or you don't because it's like on the other side the people we see that don't have a way to do something with these codes.

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

Yeah, because it doesn't go on each individual piece of data it will just go on the outside of the whole group of data that's coming across so –

**Paul Egerman – Businessman/Software Entrepreneur**

Yes in effect, I really like what Maureen presented that still shows on the slide that sort of describes the challenge at the end because the way I think about this is I think about how it all worked in a paper system where a substance abuse center would simply be completely separate from the rest of any other healthcare institution and would just keep its own separate medical record.

And so what is written here on the slides is what the fundamental challenge is. I mean, you could still do that and sort of like keep a complete silo and completely separate the data but the challenge is to try to figure out how you can somewhat integrate it into the rest of the record and do the right thing under the right circumstances.

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

You could –

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

This is Larry, let me jump in with some thoughts here and see if we can get some quick closure on this because it's a really broad topic.

So, I think the conversation indicates the relative newness of the work that HL7 is doing and that it hadn't broadly permeated either the provider or the vendor community and it would be useful to get some information about the current status of the HL7 privacy and security classification system.

Doing a little poking around I found some very interesting guidance on a May 2013 document from HL7 but it would be good to get an expert in to sort of give us the thumbnail sketch of where this is.

But I think our conversation is supporting the sense that this is relatively new and that there is needs both on the sending side and the receiving side not just to tag the data but to be able to do something useful with the tags whether it's at the document level or at the discrete data level.

So, it looks like HL7 has put forward a framework for doing that but I don't know where in the process that initiative is or – and certainly the Paul's comments about it needs to be embedded in the systems to be operational.

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

Larry, this is Jennie, I just wanted to say that I think it would be useful to get some more information about these specific standards.

I think the other thing that I – you know, hit me while Maureen was speaking is that while this particular slide is titled SAMHSA's priorities and it's in the context of 42 CFR Maureen also described that there are varying state level privacy requirements that seem to cut, at least the way I was hearing it, perhaps incorrectly, that seem to go beyond – may go beyond just the substance abuse treatment facility and may be more broadly applicable to behavioral health, mental health information or even substance abuse information outside of a substance abuse treatment facility and therefore the need to have these stronger privacy protections that are kind of crosscutting, I think, rather than just limited to substance abuse treatment facilities.

If I misunderstood that I'd appreciate hearing that and so I just wanted to make sure I'm understanding the framing of this, the scope of this particular criterion if we can get our minds around it.

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

No that's absolutely correct Jennie.

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

Yeah, it goes beyond just the Part 2.

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

And I'll jump in, this is Larry, I'll jump in on that as well. My sense is if I reflect back on some of the comments we heard is that historically even within the behavioral health world there has been some sense of segmentation that certain notes are kept more separate, more private if you will, the detailed notes on, you know, assessments and conditions and progress, observations might be separate from other notes that relate to perhaps more standard medical things of diagnoses and allergies, and medications not that those things don't interact but there is already a sense of the need to segment some of that information.

And so I think this whole notion of a privacy framework for controlling the information is broadly important to cross this sector.

**Joe Heyman, MD – Whittier IPA**

And this is Joe Heyman with a point of reality. The fact of the matter is you can't possibly keep all this information private because there is a pharmacy history that goes through Surescripts so people can see what the medications are and then can devise from what the medications are what the person is being treated for. And there are places in people's notes where those things do appear on occasion and you can't possibly filter it all out.

So, I think it's really important to try to do this, but I think that it's literally impossible and for an HIE – I actually uploaded what we have on our consent form for our HIE, we have to tell – we're planning to tell patients that it's possible that sensitive information will appear there and that if they don't want to have their sensitive information shared they shouldn't join the HIE, because we can't possibly guarantee that we're going to filter out every single sensitive thing.

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

I think that's a good point and that's reality right now and so people need to have – and this is where it gets to actually having informed consent about the – you know what may or may not leak out.

I guess some of the issues that many in the community have is that, you know, what's the balance between privacy and security versus good care coordination, quality care and good treatment? And some of this is getting in the way.

Some organizations states have decided to allow information to move forward, it is all or nothing, so patients now know that, you know, if you're joining the HIE all your information is going to be shared because there is no way for us to just take out certain pieces of information until we have data segmentation across the board, which is probably like 4 years from now or so, until that actually could take effect.

There needs to be some ground so that people with behavioral health disorders can actually get the same good quality care, coordinated care that everyone else does and some patients will not want to join an HIE or have their information go through which should be their right and ability to do so, but there are many, many patients – and in the pilot that we ran most of the patients in the focus groups they want to share their information with providers who are involved in their care and that's an important piece they're involved in their care and not relegate them to subpar care because our systems can't allow for it. So, we should allow those patients to make an informed consent.

So, I hope we can make some balance in our recommendations around there because there are some recommendations about the other types of guidance that could be provided that would open those up a little bit.

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

Thanks, Mike. I'm hearing a pause so are we at a break point and we should move onto the next phase here? Silence is consent let's do that. Next slide, please.

Okay, so we have a whole bunch of detailed slides coming up, let's go onto the next one. And these slides follow a similar format that we used with LTPAC hearing; they highlight what was heard at the hearing, what's being discussed as a proposal and then the certification criteria that would go with that. Next slide.

So, we have some general concerns about addressing minimizing burden and cost aligning with existing programs. Some consistent themes that we're hearing again strong support for interoperability, this seems to be the week that that's the word of the week I'm hearing it nonstop from everyone.

Issues around confidentiality like we've just been hearing although I do take to heart some of the comments about if you really want it private don't send it because we can't control it and then some behavioral health specific setting needs and continuing with a modular program as a way to provide flexibility to meet these needs. Next slide.

Okay, so we're now going to be diving into the details. Maureen were you going to be the lead for walking us through the nuts and bolts here?

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

I wasn't –

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

This is Jennifer –

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

Or Jenny?

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

I'll actually walk through what we heard from the testimony and Maureen can help fill in any gaps that I may have.

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

Thanks.

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

So a reoccurring theme that occurred during the hearing was, as Larry pointed out, a strong need for interoperability. Panelists seeded that interoperability is crucial; there are many providers and multiple care settings that are involved in the patient's care.

Panelists wanted ONC to implement a certification program for behavioral health EHRs that identifies that they meet interoperability standards and criteria that are required for Meaningful Use providers.

We also heard that there was a high prevalence of co-morbid conditions among behavioral health patients that dictates the need for sharing information and interoperability.

And another panelist commented that interoperability is crucial and the availability of information with these transitions in care may prevent adverse events and facilitate better determination of levels of care which could contribute to faster stabilization and decreased re-admission rates.

So, the middle slide is the current certification criteria that would support the need of interoperability, they're listed in the middle column. And Larry, do you want me to walk through the proposed areas?

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

That would be great.

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

Okay, so proposed areas for certification would be to support the ability to receive, display, incorporate, create and transmit summary care records for a common data set in accordance with the Consolidated CDA standard and using ONC's specified transport standards.

Also support the need – also support the ability of a user to electronically reconcile the data that represent a patient's active medications, problem and medication allergy list, and support the inclusion of emerging transition of care and care planning standards that are being reconciled as part of the August HL7 C-CDA ballot.

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

And this is Maureen the only thing that I wanted to add is to just highlight something that we talked about in the last call about the additional use cases here that are relevant to behavioral health and that, you know, the primary use case that we're looking at is obviously health to health, you know, behavioral health to general health care system, but we're also, you know, concerned about the integration between the healthcare system and social services systems that provide coordinated care for behavioral health patients so things like, you know, homeless programs through the Department of Housing and Urban Development.

I think I mentioned that they have the homeless management information system as well as, you know, things like criminal justice and social work programs in order to keep everything, you know, enable that type of coordinated services and care.

**Joe Heyman, MD – Whittier IPA**

This is Joe Heyman; could I just ask a question about the middle bullet there? It says support the ability of a user to electronically reconcile the data that represent a patient's active medications, problem and medication allergy list, what besides listing the information supports the ability of a user to electronically reconcile that data?

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

I have no idea. Is Sue Mitchell on? She might be able to –

**Joe Heyman, MD – Whittier IPA**

I mean, that is –

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

Yes, hi Maureen, this is Sue.

**Joe Heyman, MD – Whittier IPA**

It sounds wonderful, but all I can think of is you get a list of the patients medications and you compare it with what the patient tells you she's taking.

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

No, and actually, Joe, there is in the 2014 edition of the criteria there is actually fairly explicit requirements around this reconciliation activity. So, what they're looking for is that you're able to simultaneously display in a single view data from at least two list sources in a manner that allows you to view the data and their attributes.

And then you also have to be able to create a single reconciled list of either medications, medication allergies or problems. And then the third component is to enable the user to review and validate the accuracy of the final set of data and upon the user's confirmation automatically update your list. So, there are actually three specific activities that are spelled out.

**Joe Heyman, MD – Whittier IPA**

I see.

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

And if you want to look its §170.314 (b) (4) that's where those requirements sit.

**Joe Heyman, MD – Whittier IPA**

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul Egerman, I have a question which is, are these proposed areas for eligible providers or for ineligible providers or both?

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

So, what we've focused on here is – or, you know, I think what we're driving at is what would be most useful would be a more modular program that fits the needs across different types of behavioral health providers, but we have tried to, across the slides, kind of call out what's core across all of behavioral health and what's, you know, what kind of is relevant to only specific types of behavioral health providers.

So, for example we'll get to the kind of medication related and prescribing criteria and that's mostly relevant to the eligible providers although not exclusively. Interoperability however is, you know, across the board relevant to everyone I'm sure you already know that.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, the reason I'm asking – I'm a little confused and there are behavioral health providers who are right now buying certified systems and qualifying for the incentive payments through Meaningful Use and so I'm trying to understand this new modular certification how does that impact them?

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

Well, part of that would be determined based on how ONC implements the program, you know, I think, you know, what we heard from the American Psychiatric Association is that the numbers of eligible psychiatrists who are going after the program is very, very low, I think it was around 7% and that part of that, the reason for that had to do with kind of how, you know, Meaningful Use criteria are not very relevant to their scope of practice.

But I think there also are other issues with that, you know, other reasons that contribute and, so, you know, I think ideally what we're looking for is to, you know, what the focus here is on addressing the issues with the ineligibles but if developing a modular system, you know, is also relevant to the eligible providers I think that's only an added bonus.

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

And this is Mike –

**Paul Egerman – Businessman/Software Entrepreneur**

The other observation I'd make is if you think especially about you trying to do something for the eligibles is to be careful about adding criteria that doesn't already exist in Meaningful Use 2 or 3.

So, I look at your third bullet, on the right as I'm looking at the screen and I don't know that that's already in MU2 or MU3, and I'm questioning whether or not we should make certification for ineligibles any harder than it is for eligibles.

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

Well, this is Mike and I think I had some wording around this and I think when you look at the ineligibles if they get on board with a system that interoperable and they meet the same criteria as the eligible right now, however, they're not bound by Meaningful Use to keep up in the future, if you don't have this piece in there they're going to fall behind and, you know, when we flip to Meaningful Use 3 if they don't move forward then and that system isn't interoperable at the third level well then they're going to stop being able to communicate.

So, I think it's important that for ineligibles, eligibles will be keeping step-by-step, but for ineligibles to make sure that software that they buy continues to be certified or they know it's not certified anymore I need to get something else if I'm going to continue to be able to communicate with everybody.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, my point Mike is just to say, I agree with what you're saying, I'm saying though that we should be sure that what the ineligibles have to do is not harder or has more criteria than what the eligibles have to do.

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

Oh, I agree, I think it should be just in step, in line with what the eligibles have to do but they can just buy just this one thing, yeah, I agree.

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

So, I just want to provide a clarification, this is Liz, the first two bullets are in MU2, the third bullet was a recommendation from the Meaningful Use Workgroup for MU3. So, this is part of MU.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, but that third recommendation hasn't been approved yet and the reason I point that out is I am one of the people who were questioning that third recommendation. So, I just wanted to say that we need to keep these things synchronized. So, if it's not approved for MU3 it really shouldn't be here either. If it is approved for MU3 then I don't have any trouble with it being here.

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

Yeah.

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

This is Jennie Harvell, and I'm sorry, was that Paul who was just speaking?

**Paul Egerman – Businessman/Software Entrepreneur**

Yes.

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

Yeah, I agree with your comment there about keeping the interoperability requirements for these ineligible providers in sync with both current interoperability requirements for the eligibles as well as what's emerging as an interoperability requirement for those eligibles.

The other thing, I do have a question, Maureen and Sue maybe you can answer this? On the first bullet there where it's talking about the common data set and then thinking – looking back to the information in the left-hand column somewhere in there I think I saw reference to, you know, needing to know the person's diagnosis or condition or maybe it was just in your overview of that – of the testimony that we heard. Do the common data set include – I think the common data set includes diagnoses and do the identified vocabularies for use in representing those diagnoses include the DSM?

**Paul Egerman – Businessman/Software Entrepreneur**

No.

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

Not yet.

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

Yeah, I was going to say Jennie, this is Sue and Mike is correct when you look at what's currently spelled out in the rules they require diagnoses to be encoded in SNOMED. There is no reference to DSM.

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

And Sue the current vocabularies – so it's SNOMED and what other clinical vocabularies are also referenced in the current requirements?

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

Okay, so for problems of course it's going to be SNOMED. Medications or medication allergies they're looking for RxNorm. With lab tests they're looking for LOINC. I just lost where I was. What else do we have? Then there are some other ones related to like with race and ethnicity, using the OMB requirements, preferred language there is an ISO standard. But I think the big ones are going to be SNOMED, RxNorm and LOINC.

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

And is ICD-9 called out anywhere?

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

Actually, I don't think they do.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, this is Paul; I have to remind you we're all switching to ICD-10.

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

Okay, so is ICD anything called out anywhere?

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

I'd have to go back Jennie, okay, so there is – can I dig back into this Jennie and – because it's one of those intertwined things I have to figure out where it all starts.

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

Yeah, I thought it was ICD-10 up until when SNOMED kicks in for everything they're still using ICD-10.

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

Right, there is a reference to code sets and it does say ICD-10 but I'm trying to figure out what's pointing to this requirement Jennie, so I've got to do some backpedaling here.

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

Yeah, the reason why I'm asking is whether or not in supporting these recommendations on this slide whether it's important to also reference the need to use – to also include support for DSM as one of the vocabulary code sets to be used.

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

Right, well and actually the other question I had in just looking at the way the first bullet was specified on the right-hand side it does call out the intent to use the specified transport standards. Was the intent to also use the specified vocabulary standards that was my other question.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and this is Paul, it seems to me that DSM would be an interesting and potentially controversial issue here, because again that's something that's not a requirement for the eligible behavioral health providers and then it also has other implications. So, when you get to clinical decision support I think those systems are not set up to run on DSM or I suspect they are not.

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

Yeah, there is a good crosswalk between ICD-10 and DSM, there are a few codes that don't crosswalk exactly, but like I think people who have looked at this it's like 97% of it does crosswalk ICD-10 and DSM so it's pretty good there.

I had a question though on the first bullet to support the summary of care record and the data set. The only caveat I have there is if a behavioral health provider didn't have vitals and I believe that's part of the data set if you don't have that does that restrict the transmission of the data or is that something you can just say "I don't have it."

I would not want to put vital signs, a social worker or psychologist are probably not going to have vital signs if they're using this. I would not want that to restrict the data from flowing. They should be able to just say "hey, I don't have it" and allow the rest of the data to flow.

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

Right, so sometimes the Consolidated CDA would certainly support the ability to fill in the vital signs with a “null” designation.

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

Okay, that’s good.

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

So, from the content exchange data you’ll be fine.

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

Okay, all right, that’s great then.

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

So can we…

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

–

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

I just wanted to hear what – in terms of like getting to whether or not does this support it or not if we could have a yes or no?

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

This is Jennie I support it with the modification that I think it was Paul’s to keep these recommendations in sync with both current and future states of Meaningful Use requirements.

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

This is Mike, I agree.

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

All right.

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

This is Joan, I agree as well.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, I agree Paul.

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

Larry, I agree as well.

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

Yeah, Liz agrees.

**Joe Heyman, MD – Whittier IPA**

Me too, Joe.

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

Me too, John Derr.

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

Thank you.

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

Okay, let's move on.

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

Okay, as we heard earlier there was another major theme from the hearing surrounding privacy and security functionality. The testimony we heard, some of the key points were federal laws protect the confidentiality of substance abuse treatment data. Approximately half of the states have similar laws protecting the confidentiality of mental health information.

There is a need for EHR systems to support compliance with these laws which include the need for consent management, standards for communicating consent policies, controlling redisclosure of information.

Consent requirements including the need to name specific providers or provider organizations to consent are current presenting barriers to HIE. And finally there was support for granular data segmentation when standards are ready.

Proposed areas for behavioral health certification would be to support existing ONC certified privacy and security requirements and support inclusion of standards for communicating privacy policies such as the HL7 privacy and security classification system and controlling the redisclosure of protected data.

For future work ONC should consider supporting equivalent functionality in MU3 for standards for communicating privacy policies and controlling redisclosure of protected data and should also incorporate granular data segmentation when it becomes available.

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

So, this is Larry, let me jump in right at the beginning. It looks like our second bullet here in the proposal is actually in the future work. Is that correct?

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

Yeah, I was just going to say the same thing, this is Mike.

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

So, the reason why we split that out is because, you know, so within – is because this committee is focused on the voluntary certification.

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

Right.

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

We would like the committee that is addressing the Meaningful Use certification criteria to, you know, to take this up for MU Stage 3 and so that's why that was put like kind of split but, you know, for the behavioral health voluntary certification we think it should be included and we think separately that the MU3 committee should address that as well.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and so this is Paul, I just wanted to I guess state that the principle or the concept I was trying to do on the previous slide which is this process should not get ahead of where the rest of the certification Meaningful Use work is.

And so if we want to make a recommendation that something is included in Stage 3 that would be fine and if it succeeds that would okay to include it, but I don't think we should be making a recommendation for inclusion of standards that doesn't exist within Stage 2 or Stage 3 and I think especially because that's going to be minimally effective, right?

You know, I mean, if we're talking about transitions of care the whole concept is everybody should be using the same standards. You can't have ineligible providers using a standard that's different than, you know, an eligible primary care provider.

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

Yeah and this is Mike, I totally agree with that. I see this as part of the future work and, you know, I don't see this so much as an EHR problem as it's more of an HIE problem, but in any event, this should be part of the future work. I would not want to impose this on a voluntary certification process until it's in line with what everybody else is able to do.

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

Yeah, but this is what –

**Joe Heyman, MD – Whittier IPA**

This is Joe, I would also agree with that and I have a concern about this controlling redisclosure I don't know how an HIE is capable of doing that.

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

Well that's the problem they have right now.

**Joe Heyman, MD – Whittier IPA**

Exactly.

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

Yeah.

**Joe Heyman, MD – Whittier IPA**

So, I mean just sticking it in there without having a solution just seems to me to be very, very premature.

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

Well, but the HIE issue is separate from the EHR issue. So, you know, being able to do the point-to-point and have the EHR control redisclosure I think is somewhat doable at this point, you know, especially, you know, if they have a simple solution like the data siloing and I would be very much in favor of – I can't remember – I don't know who actually said this before, but, you know, of making the recommendation to have this looked at by the Stage 3 committee and if it goes through there than having it included here.

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

Yeah, I would agree with that Maureen, yeah, this is Mike. But I wouldn't want it to stand out by itself the way it is right now.

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

No I think Stage 3 is the right place to start.

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

I had –

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

Yeah, this is Larry, I think that we're going to see that because of all of the interdependencies we've described this is a great thing for ONC to signal and created a roadmap for but a very tough thing to bring up quickly because we're going to have, you know, flags, metadata in place that systems don't know how to interpret.

I think it's fine to – it's my sense in bringing up the question at the beginning was to leave the bullet about specific reference to HL7 privacy and security classification as part of asking the Meaningful Use Group to review as an emerging need, actually as an emerging answer to a need and our Standards Committee buddies to validate the status of where that work is in terms of how soon it can be incorporated into the Meaningful Use criteria.

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

Larry, this is Jennie, I agree with what you just said. I think when directing that request to the Meaningful Use Stage 3 – to the Workgroup that's focusing on Meaningful Use Stage 3, I would underscore in that communication the critical need for this type of standard to support information exchange on behalf of person's receiving behavioral health services and the providers who care for them, because given what we heard last week or at the last meeting about this and what Maureen was underscoring earlier today the sensitivity of much of this information I think needing to identify a standard and have EHRs be able to support that standard is really important not only for EHRs in behavioral health but across the care continuum.

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

Right, as you mentioned before it goes beyond behavioral health.

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

Yeah for it to be effective it has to be implemented broadly. So, cycling back the criteria in the center or the dark ones are part of the required criteria today broadly speaking the 2014 edition and those are the things that we're saying we want to go forward on including an optional accounting of disclosure recognizing that that's still a hot topic with final rules awaiting.

**Paul Egerman – Businessman/Software Entrepreneur**

That's right and this is Paul, just one minor observation, we tend to focus a lot on the privacy part a lot of what you see in that little area is security which is very good and totally appropriately to be included, but the security is very important.

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

Right sort of foundational, if we don't have security –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, authentication and authorization, yes.

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

Right. So –

**Joe Heyman, MD – Whittier IPA**

You would have to change the tone of the way that is written there now because the second bullet makes it sound as if we're suggesting that this should be done for behavioral health and then future work should consider supporting it in Meaningful Use 3.

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

Right, so we're looking –

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

Right.

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

So, this is Larry, Joe, I agree that this needs to be done broadly, it's an issue that comes up specifically among behavioral health providers but you could imagine that it's not just behavioral health, in the state examples it is clearly expanded beyond just behavioral health. And your examples of issues with HIEs today and their inability to segment highlights that as well.

So, my sense is that we're saying that the heading future work needs to move up to include support for inclusion of standards and that our language needs to communicate that this is a specific need in this area but to meet the need – well and it's not only a need in this area really is the case.

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

**Joe Heyman, MD – Whittier IPA**

I would just say one more time, just for the sake of saying it, that you can have all the standards in the world but you're not going to be able to completely protect all that information it just is not possible.

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

And I think that those are both true statements, right? We want to put in place –

**Joe Heyman, MD – Whittier IPA**

We can only do the best we can.

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

Controls but we also need to recognize it's not going to be perfect.

**Joe Heyman, MD – Whittier IPA**

Right.

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

So, with that are we ready to thumbs up or thumbs down on this?

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

With the change that was recommended that the second bullet go under future work I would approve I think.

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

This is Maureen, I do as well.

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

This is Jennie, I agree.

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

Joan agrees as well.

**Joe Heyman, MD – Whittier IPA**

Joe as well.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes.

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

Yes.

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

This is Larry as well. I'm assuming no dissents so we can move on is that correct?

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

John as well.

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

Okay, let's move on.

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

All right consent management, we heard a lot of testimony on the need for consent management which is specific to the behavioral health setting. Key themes, we've already heard the first key bullet several times so I'll skip down. There was a need for EHR systems to support compliance with these laws and enable automated consent management through electronic signatures, standards for consenting and communicating consent policies and standards for communicating privacy obligations.

Proposed areas for behavioral health certification, to support the use of HL7 privacy and security classification system, to tag records, to communicate privacy related obligations with the receiver and around future work to develop consensus on standards for consent management functionality needed by behavioral health providers to comply with the diverse federal and state confidentiality laws.

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

So, in keeping with our earlier discussion doesn't that first bullet move into future work as well?

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

Yeah, I think so.

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

Yes.

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

I agree.

**Joe Heyman, MD – Whittier IPA**

Me too.

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

Yes.

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

Do we need any further discussion on this? It seems like we've covered all this in the prior slide.

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

Yeah.

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

Okay, so are we good to accept this given that we're moving the recommendation into future?

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

This is Maureen, yes.

**Joe Heyman, MD – Whittier IPA**

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes.

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

Yes, Mike.

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

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

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

**Joe Heyman, MD – Whittier IPA**  
The unnamed was Joe.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**  
Larry, yes.

**Joe Heyman, MD – Whittier IPA**  
That was a yes.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**  
Larry is yes as well.

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

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**  
Thank you, record time, let's move on.

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**  
Okay, clinical health information, so during the hearing we didn't hear much comment about the specific functionality that would be needed on this slide, but a few commenters specifically addressed the need for problem list, medication list and medication allergy list.

So, for example one commenter seeded that their experience is that medical doctors are mostly interested in receiving information from behavioral health providers on medications, diagnosis and repeat labs. And another panelist indicated his agreement for the need for medication information.

So, in the proposed areas for behavioral health certification we proposed to support the ability to record, change and access the following data standards using ONC's specified standards, demographics, problem list, medication list, medication allergy list, family health history and smoking status. In addition support the ability for a user to electronically record, change, access and search electronic notes and support the ability to electronically and dynamically select, sort access and create patient lists. And to get to the point that was discussed earlier that we should consider including DSM-V standards.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**  
So, I just have one question.

**Joe Heyman, MD – Whittier IPA**  
What about –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**  
Oh, I was going to ask one question, on the proposed certification when you refer to the user or the ability to support are you talking about the behavioral health provider?

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**  
Yes.

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

Okay, thank you.

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul –

**Joe Heyman, MD – Whittier IPA**

–

**Paul Egerman – Businessman/Software Entrepreneur**

I don't understand is everything you have on the blue area included in the middle?

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

Yes it's just specifically calling out the functionality.

**Paul Egerman – Businessman/Software Entrepreneur**

So you're just describing the functionality that – because I look at this and that's what I thought it was, but I just wasn't sure. So, in other words it still follows the concept there is nothing new being proposed here?

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

Exactly.

**Paul Egerman – Businessman/Software Entrepreneur**

As it relates to MU2 or 3?

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

There were some questions on the LTPAC regarding, you know, what the criteria involves so we just spelled it out.

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

I just have a question for clarification, is searching in electronic notes isn't – is currently included?

**Paul Egerman – Businessman/Software Entrepreneur**

The proposal for MU3 includes the ability to search the text.

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

Okay.

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

Yes, Stage –

**Paul Egerman – Businessman/Software Entrepreneur**

It says, it's a text style search.

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

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

You know you look for the word path –

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

I had not seen that before, all right, thank you.

**Joe Heyman, MD – Whittier IPA**

This is Joe –

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

And, well, and actually this is Sue and I just wanted to say actually in our 2014 edition the language of electronic notes says enable a user to electronically record, change, access and search electronic notes so that's already a requirement.

**Joe Heyman, MD – Whittier IPA**

This is Joe –

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

Okay, thank you.

**Joe Heyman, MD – Whittier IPA**

Can I just ask – I mean, there is obviously something blatantly missing here which is past history and surgical history, is that still not a requirement somewhere?

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

There is a family history.

**Joe Heyman, MD – Whittier IPA**

I mean, family health history is not nearly as important as the patient's own past history.

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

It is not in the current certification Regs Joe.

**Joe Heyman, MD – Whittier IPA**

Just blows my mind. Okay that's what happens with regulation. I would suggest putting it in the future work, getting a past history and a surgical history for a patient into Meaningful Use it's more important than a whole lot of other things that are in Meaningful Use.

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

Yeah, I'm surprised it's not there, I mean, I would –

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

I'm willing to – that additional bullet.

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

Yeah for behavioral health not so much surgical, they're not doing so many surgeries, but certainly the past history is very important, yeah.

**Joe Heyman, MD – Whittier IPA**

Well for behavioral health I would agree that surgical history may not be important.

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

Yeah.

**Joe Heyman, MD – Whittier IPA**

Although it may be important because –

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

Yeah, I would agree.

**Joe Heyman, MD – Whittier IPA**

It could be a crisis point in somebody's life.

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

True, yeah, I would include both.

**Paul Egerman – Businessman/Software Entrepreneur**

Does it have any impact on medication ordering or on clinical decision support? I'm just curious.

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

If they just had a surgery then I would think so, yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

If they had their thyroid removed or something does that change the medication you give?

**Joe Heyman, MD – Whittier IPA**

Sure.

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

Yes.

**Joe Heyman, MD – Whittier IPA**

Sure of course it does.

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

So, under clinical decision support they do look for you to be able to check the problem list and determine if there are conditions that impact your medication regimen, so I would think –

**Joe Heyman, MD – Whittier IPA**

Yeah, but problem list doesn't – I mean, problem list is completely different from an actual history.

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

Yeah –

**Joe Heyman, MD – Whittier IPA**

But anyway I'll just leave it off, I mean, I'm not surprised and I'm –

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

No I wouldn't want to leave that off because as you're talking through it I'm talking about how many people we treat in behavioral health that have traumatic brain injury and that comes up and that's a very significant thing that we miss all the time because we don't ask that question. So, I would think we would want to include that like you said.

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

Well, yeah –

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

I would not want to leave that out.

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

And again, Mike, I mean, I think the expectations that something like TBI would be reflected somehow on either the problem list or encounter diagnosis and both of those do show up, but, you're right –

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

Maybe –

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

The actual history itself as we have known it over the years that's not part of the MU requirements.

**Joe Heyman, MD – Whittier IPA**

So, why isn't it? Why does it take so much effort to get something as simple as that stuck in there? I just don't understand it.

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

Too bad Paul Tang didn't make the call today he could probably answer that.

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

Yeah, I think – I will tell you that there is a lot of assumption that a lot of that information is in the electronic health record already. I think where we may have dropped the ball is the passing of the information to other partners in care.

**Joe Heyman, MD – Whittier IPA**

Well that's what I'm talking about.

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

Right, I understand.

**Joe Heyman, MD – Whittier IPA**

Somebody accused me of a rant at that hearing when we were talking about this, but I've got to tell you it's very, very frustrating.

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

Right.

**Joe Heyman, MD – Whittier IPA**

Not to be able to transfer that information.

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

Right. Well, and again, I think the catching point there is electronic, because when we send our documents to receiving entities, you know, we do include the admission note, the discharge note, the history, I mean, we do, but it is not required for us to do it electronically, it doesn't mean we don't do it, frankly we do, but it is not required.

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

And I'm going to go out on a limb and – I've got to go back and research it, but I would be willing to, you know, lay down on my sword that in the Consolidated CDA that there is a section that supports –

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

That's right, yeah, I was thinking the same thing, I was thinking about that long list of everything that's supposed to be in there and I don't remember.

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

So, I think –

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

No it's in there, it is in there.

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

Yeah.

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

But it's just not explicitly –

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

Yeah.

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

Required that you complete it as part of your certification process or –

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

Right.

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

MU requirements.

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

I will tell you though even with that document it does say as available or something like that. So, again, ones for the care providers are very conscientious because they've realized like what Joe is talking about the criticality of that information the better care for the patient and it's only if it's not available, but they have – I mean, if you have nothing you still send everything you have.

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

Right.

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

So, Joe we're with you.

**Joe Heyman, MD – Whittier IPA**

Thank you.

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

Okay, so to get us back on task here, so the recommendations here are to pull forward some of the core elements that are in the existing certification criteria and applicable in this space including the notes, the electronic notes piece that we learned searching is in MU2, I guess we're all in our learning phase about MU2 going real.

And the future work should address two things the bullet that's here inclusion of DSM as part of the standard code sets and recognizing some of the comments we've heard about if you want those codes to be available for decision support it's not as easy as just saying here's a new code set.

And second, to add our observation that history, patient history is missing and that we heard that was actually a very important thing in these care settings.

**Joe Heyman, MD – Whittier IPA**

Joe, yes, just to move things along.

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

Mike, yes.

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

Liz, yes.

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

Jennie, yes.

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

Joan, yes.

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

John Derr, yes.

**Paul Eggerman – Businessman/Software Entrepreneur**

And yes Paul.

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

Larry, yes. Next slide, please.

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

All right another area we heard a lot about was clinical decision support. One commenter commented that it was the most needed function is linking CDS software to managed care, primary care and EDs. There is a strong need for standardization since clinical decision support mechanisms can help spur the use of EHRs as well as eliminate more labor intensive capacity management processes such as the use of spreadsheets to track referrals and waiting lists.

So, proposed areas for certification are to support the ability to have evidence-based decision support linked referential clinical decision support, clinical decision support configuration, automatic and electronically interact, I think, and source attributes.

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

This is Mike, on this particular thing I think the clinical decision support needs to be targeted to whatever is current and future Meaningful Use clinical quality measures and then they can do over and above that.

If the clinical decision support isn't targeted to the Meaningful Use clinical quality measures I think people are going to be playing on a different page than everybody else they're sharing information with so I think that's an important distinction.

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

So, in the 2014 editions for Stage 2 that is covered at least at some level. So, I'm not sure – I don't have the numbers memorized, but we want to look at that, because you do have to tie, in fact you have to tie to each, 3 of the 5 domains.

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

Yeah, so as long as it's tied to those and you can do over and above I'm good with it, but maybe you need to say something specific about it.

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

Yeah the only other thing I saw was – and I guess – wasn't able to attend the hearing, is they've asked about the managed care and that sort of thing and that certainly is not covered and has a whole different set of verification to it.

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

And the other thing –

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

Correct.

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

This is Maureen, the other thing I would mention is some of the different provider types within behavioral health have suggested that there aren't really quality measures in the –

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

Right.

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

Better relevance to them, which we're going to cover in the next slide, but just that needs to be taken into account.

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

Yeah, that's why I think they can do over and above, but it at least needs to meet the Meaningful Use ones.

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

Yeah, so this is Jennie Harvell, I'm not being very fluent in the clinical quality measures that are being or will be advanced for behavioral health. Maureen following up on your comment I'm not sure one whether they exist right now. Two, whether what emerges will be applicable across sectors within the behavioral health community.

And if the answer to the second question is that there may be behavioral health for whom those measures will not be applicable or relevant, I would discourage linking the clinical decision support to those metrics because if they're not applicable then – I mean, we've heard in several of these hearings about – in fact, I think maybe Paul it was you and then I think maybe we also heard from Stan Huff talking about how trying to require something that doesn't work and doesn't fit within a clinical workflow is, you know, really disruptive and not productive.

So, you know, to me having a more generic clinical decision support criteria, evidence-based would be useful in behavioral health as well as, you know, other sectors as well.

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah.

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

But again –

**Paul Eggerman – Businessman/Software Entrepreneur**

This is Paul, because I also look at this and I'm thinking well a lot of what we're calling clinical decision support involves, you know, ordering medications, ordering laboratory tests, but we're also thinking about the ineligible providers like psychologists and do they do that stuff?

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

The psychologists don't but, this is Mike, there are 18 clinical quality measures now that are behavioral health specific and I think 15 of them are specific just behavioral health and then another 3 is if you're working in integrated settings. They're not all around medication management, some of them are, some of them are, you know, an example is within diagnosing the person with a substance use disorder they should be referred to treatment within 14 days and actually have 2 visits within 30 days, that's across the board, it's not medication specific. There will be more coming down the road.

Under Meaningful Use 1 there are only 3, so under Meaningful Use 1, yeah, then they didn't make any sense. Now they're 18 and those 18 do make sense. If we don't tie it to those and we want – and we're thinking about our behavioral health providers playing in the medical arena with everybody else who is getting incentive payments based on meeting Meaningful Use criteria well then they're not going to be able to play and they're going to be an outcast and we don't want behavioral health to be an outcast we want them to be included with everyone else, so I think we have to target to that and allow the systems to do over and above, but if you don't target to that I think we're again putting behavioral health on the side and not including it with the rest of medical care before healthcare.

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

This is Sue and if I can just jump in for a second, I believe – because we're talking about, you know, what's included in the requirements about evidence-based clinical decision support and so I think you all need to know that the way the requirement is structured they actually identify 6 different components if you would looking at problem list, medication list, medication allergy list, demographics, lab tests and their results and vital signs.

And what they say is that you have to be able to do clinical decision support based on each of those six types of content and at least one combination of two of the content – data content types. And so this is actually above and beyond doing drug-drug and drug-allergy interactions, you know, that's looked at separately, but –

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

Right.

**Joe Heyman, MD – Whittier IPA**

But does it address the 18 measures that were just mentioned?

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

The quality measures, yeah.

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

Yeah in the mix it would, yeah, that would.

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

Yeah it would.

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

– identified it would and because Meaningful Use providers have to focus towards those domains and all the NQF measures these behavioral health measures all of them are NQF except for one, the one on Alzheimer's, so they would all be addressed in that same way.

**Joe Heyman, MD – Whittier IPA**

So they would all be triggered by one of those criteria that were just mentioned?

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

Yes.

**Joe Heyman, MD – Whittier IPA**

The problem list, the demographics, the whatever the others were.

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

Yeah it would fit into some of that.

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

In patient, lab results, right.

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

If you targeted it towards those 18 and used demographics say for all my geriatric patients because one of them is, you know, doing a risk fall assessment which you wouldn't think is behavioral health but so many behavioral health providers treat geriatric patients that have a mix of medications, well it fits perfectly with geriatric behavioral health practice.

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

So, this is Maureen, I just want to like, you know, I think because of the different types of behavioral health providers and the different types of workflows that we're talking about some of them would, you know, would have quality measures that are in the current program that are relevant to them but many of them still wouldn't so most of these are really focused on ambulatory care settings and there is virtually nothing for kind of hospital-based settings.

And also, you know, a lot of these are really focused on behavioral health care within a primary healthcare domain so things like screening for depression and follow-up and, you know, so I would just advocate for flexibility in that such that if the quality measures that are in the program are not relevant to their scope of practice but it doesn't, you know, keep this from being relevant to them.

**Joe Heyman, MD – Whittier IPA**

But I think what's happening is that the EMR companies will have to put all of the measures in.

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

That's right.

**Joe Heyman, MD – Whittier IPA**

Because they can't –

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

**Joe Heyman, MD – Whittier IPA**  
They can't decide who is going to be using which.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**  
That's right.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**  
Yes, that's correct.

**Joe Heyman, MD – Whittier IPA**  
I just worry about the cost of EMRs and how this increases it that's why I keep –

**Paul Egerman – Businessman/Software Entrepreneur**  
Well, yeah.

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

**Paul Egerman – Businessman/Software Entrepreneur**  
This is Paul, what you're saying Joe is a good question because it's a comment, because that is sort of like why I was commenting about the question I was asking about the psychologists –

**Joe Heyman, MD – Whittier IPA**  
Right, I don't want a psychologist to have to pay for a psychiatrist's EMR is what I'm trying to say.

**Paul Egerman – Businessman/Software Entrepreneur**  
Yes and when you create one-size-fits-all certification, you know, you end up with possibly people buying a lot of stuff that they never have any reason to use.

**Joe Heyman, MD – Whittier IPA**  
Exactly.

**Paul Egerman – Businessman/Software Entrepreneur**  
So it's a barrier.

**Joe Heyman, MD – Whittier IPA**  
That's why Microsoft Word is so expensive.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration**  
So, is there a recommendation we could make in that realm to kind of, you know, is there a way to build off of what's in the Meaningful Use Program but to make it more flexible for the ineligible providers and, you know – so I know in a separate one we're going to be talking about the quality measures and stuff and having the Quality Measure Workgroup look at, you know, quality measures that are relevant across the ineligible behavioral health providers.

**Joe Heyman, MD – Whittier IPA**  
But the thing is we're not talking about Meaningful Use requirements we're talking about certification requirements.

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

**Joe Heyman, MD – Whittier IPA**

So, we're not really requiring these folks to do this what we're requiring is the EMRs to be able to do this.

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

Right.

**Joe Heyman, MD – Whittier IPA**

And so my only concern is that there are a lot of people in behavioral health who would not be using this functionality but they would still have to pay for it.

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

Well, not if you're doing a modular approach. I mean, if you're – I mean, if this is a module and I'm not doing it I don't buy that module and I thought that was the whole idea was that this was going to be a module approach. So, I would see the clinical decision support as being a module that I either want or I don't want.

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

This is Jennie, Sue can you please read again the requirements for this particular – under the current ONC requirements for this function?

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

So, we're actually looking that the clinical decision support be able to be triggered off of six items the problem list, the medication list, the medication allergy list, demographics, laboratory tests and vital signs. So, they have to be able to trigger off of each of those six and then one combination of two of those six components.

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

So, a system would need to have clinical decision support for each one of those six domains plus one combination domain, combination area?

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

That's my understanding here Jennie as I'm reading it.

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

And if you're a Meaningful Use provider those are usually targeted using one of those domains against the Meaningful Use clinical quality measures otherwise it doesn't make any sense that the Meaningful Use –

**Paul Egerman – Businessman/Software Entrepreneur**

And in the proposal for MU3 includes structuring, family history, including family history as part of clinical decision support or maybe that's the proposal.

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

Yeah.

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

And so I –

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

I'm afraid if we put out a voluntary program and this is a module and people don't know that this module either does or doesn't meet the Meaningful Use requirements they're going to be wasting their money because they're going to be buying stuff and in the environment of coordinated care they're not going to be coordinating with anybody because they're not going to be on – you know, looking at this is not going to be looking at apples to apples.

So, I think it's really – that's why I think it's so important to do that and I agree with Maureen put in the flexibility to, if it doesn't apply to you say this doesn't apply and then the vendor would say, yeah, I don't do anything Meaningful Use but I have all these other clinical quality measures I'm okay with that but I think it's important to flag that it does or doesn't provide the clinical decision support for the MU quality measures.

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

Okay, so –

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

Hey I just have to say this conversation about quality measures relative to clinical decision support is quite confusing to me in the context of the ONC EHR Certification Criteria for the eligible providers. Sue, correct me if I'm wrong, but I do not believe that the ONC Certification Criteria on clinical decision support says anything about quality measures.

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

That's incorrect.

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

And that's correct Jennie.

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

I'm sorry, Sue say it again please?

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

Oh, I said that's correct Jennie.

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

That clinical decision support does not reference quality measures?

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

Correct.

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

Okay.

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

That's – I'm sorry, this is – is that for EPs or EHS? This is Liz.

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

Well, Liz, so it sounds like you think that it does reference the quality measures?

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

For EHs you have to have a clinical decision support that ties to at least four of the quality measures and they have to be representative of at least three of the five domains and I'll be glad to send out that reference for you guys.

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

Yeah and ambulatory you need to pick three from each of the three menus.

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

Right.

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

So that's the same for ambulatory.

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

Right.

**Joe Heyman, MD – Whittier IPA**

Yeah, but –

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

Are we in a gap here between certification requirements and Meaningful Use objectives.

**Joe Heyman, MD – Whittier IPA**

Yeah, I think we are.

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

Is that where we're coming from?

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

Yes, this is Michelle –

**Paul Egerman – Businessman/Software Entrepreneur**

That's correct.

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

So it's not explicitly maybe – I think what Sue is referring to, might not explicitly be in the certification criteria, but for the Meaningful Use Stage 2 objective related CDS it has to relate to clinical quality measures which it clearly states. So, I think that's the ambiguity.

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

Larry your observation is correct though. We're starting to talk about what the Meaningful Use requirements are but this is just certification.

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

Exactly.

**Paul Egerman – Businessman/Software Entrepreneur**

And just to be clear, because I'm not clear on this, is what's proposed on the blue thing exactly the same thing as what's in the middle, you just wrote it with words that are different words so we can understand it?

**Jennifer Frazier, MPH – Policy Analyst – Office for the National Coordinator for Health Information Technology**

Yeah it's just a high level summary of the current 2014 certification criteria.

**Paul Egerman – Businessman/Software Entrepreneur**

So the proposal is basically to do the same thing for clinical decision support that is done in Stage 2.

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

Right what you see listed in that far right hand column are actually the various subparts of the requirements related to clinical decision support.

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

Okay, this is Mike, then if it does then it is in alignment with that and I'm fine and I would then add what Maureen said if it doesn't apply then make it flexible to go over and above that.

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

So to go over and above again it refers to Meaningful Use criteria that we're not addressing because there is no MU Program for these providers.

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

Well –

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

This criteria talks about capabilities of a system to do decision support not what the rules are.

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

Well if you're just looking at the ineligible providers well then yeah, but this applies to eligible providers.

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

But, even for the eligible providers the certification criteria, the capability of the EHR is a foundational piece that the Meaningful Use objectives then build on. Most of our discussions for the last year have been about –

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

I thought it was – I thought it was the other way, I thought the Meaningful Use measures were described and then the criteria was built to ensure that the vendor would be able to provide us with functionality that would allow us to meet the measure, is that right?

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

That's what I thought.

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

Yes.

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

Well, actually, Liz, you're probably correct, thank you.

**Paul Egerman – Businessman/Software Entrepreneur**

And I –

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

–

**Paul Egerman – Businessman/Software Entrepreneur**

This is Paul I think you're both right. I think what Liz just said is most of it, but there are some criteria that are just criteria.

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

Yeah, you're right.

**Paul Egerman – Businessman/Software Entrepreneur**

But there is –

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

But our activity here is focusing on EHR certification criteria and we're not thinking – I thought this – you know, what's Meaningful Use is not the scope of this activity.

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

So, I think –

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

Well if you want providers to be able to coordinate care I think it certainly is, because otherwise who are they going to be coordinating care with? I don't understand how they would coordinate care along these measures, an ACO wants all their providers to work on this, my system doesn't, I just bought this system it's certified but we didn't make sure it was certified because if they're in alignment with the ACO they just bought and wasted their money, that's the –

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

Right, well, but Mike – so Mike that concern is going to be real regardless because with a modular program vendors will say, I am certified and you need to ask the next question, what aspects of your system are certified, I have to do decision support, did you do the decision support criteria.

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

Okay, so maybe we just – somehow the providers need a flag for that, so maybe you have – maybe you break it up into two things clinical decision support for Meaningful Use and clinical decision support for –

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

But it's the same, it's the same, the certification criteria is silent about the Meaningful Use requirement.

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

Right, yeah.

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

Okay.

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

Because Mike all the certification requirements are saying is how the software has to behave and what it says is that when you're doing decision support you need to be able to look at the problem list and the medication list, and the vital signs and trigger something that will tell you what exactly you're looking at as far as, you know, am I triggering based on specific lab results in combination with dates, if we're doing a condition, you know, in combination with the medication, I mean, it doesn't tell you that it just says you have to be able – your software needs to be able to be configured to run certain decision support algorithms.

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

Okay.

**Joe Heyman, MD – Whittier IPA**

So, what that actually – this is Joe, what that's actually saying is if I were an EMR vendor and you stuck that into the requirements for my behavioral health record and I already have another record that I use for my regular EMRs I would probably just throw in the same decision support that I'm doing for my regular EMRs into the certification ability of my new EMR rather than to think about what a behavioral health person needs.

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

And then maybe you wouldn't have a very big behavioral health clientele.

**Joe Heyman, MD – Whittier IPA**

Exactly, which is my point about certification is I would try to keep these affordable and minimize the requirements on certification because you want to have a big clientele using them and being able to communicate with everybody else.

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

Right, exactly and so on this specific criterion the way it's structured in the Meaningful Use Program and, you know, given what Sue read to us, which is you need a clinical decision support for each one of those I think six areas, you know, if you're a social worker are you getting labs tests?

**Joe Heyman, MD – Whittier IPA**

No.

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

Yeah, right, and, you know, so I'm wondering – and so this is kind of in contrast to the general principle we were working under earlier in this conversation, I'm wondering if this particular criterion should be something like support one or more, you know, support clinical decision support for one or more of the following domains and so you've got the list problem list, medication list, medication allergies, demographics, lab and so, I mean, problem list I would assert that every behavioral health provider is addressing one or more items on a problem list. So, there should be at least clinical decision support for that.

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

So, Sue, let me ask you a question. So, when I – I'm getting confused, so when we talk about certification criteria and it's how the vendors build their tools to give us that's different from what we have to do to meet a Meaningful Use measure.

So, are you suggesting that the vendor would only have to provide you with one or you would like the options of all and then you could use what you wanted?

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

So, it was Jennie who was making that comment.

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

Oh, I'm sorry, I'm sorry, Jennie.

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

That's okay. And so what – and so I'm trying – my suggestion was the vendor could, but maybe your approach is better, but it seems your approach would have more costs embedded in it.

What I was thinking is that a vendor could – if with this modified certification criteria a vendor could choose one or two, or all, you know, however many they wanted, you know, but minimally choose one of these areas to have clinical decision support, clinical decision support for the problem list.

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

So, yeah, right, so Jennie the reason we have tried in the past to avoid that on the current eligible providers is that as customers we are then limited to the functionality we give.

So, if your vendor picks “x” and that's really not the one that you thought was the most useful in your setting that's the only option they have, they're obligated to give you.

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

Yeah, right and so then it places some burden on the provider –

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

Yeah.

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

To understand what they're purchasing.

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

Right.

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

But on the other hand –

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

–

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

If they purchased, you know, if they included all six at least some of these providers would be purchasing functionality that they don't need –

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

They didn't need.

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

And have the cost associated with it.

**Joe Heyman, MD – Whittier IPA**

Also, you know, there are independent social workers, their incomes in a year would have a significant portion of the cost – I mean, would be – these EMRs cost a significant portion of their annual income –

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

It depends –

**Joe Heyman, MD – Whittier IPA**

Because they don't get paid the way other providers get paid.

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

Well you know I am one of them and have been one of them, so, you know, we don't make a lot of money

–

**Joe Heyman, MD – Whittier IPA**

Exactly that's my point.

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

But there are some –

**Joe Heyman, MD – Whittier IPA**

That's my point.

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

Smaller three or five hundred dollar a year EHRs that are Meaningful Use out there that you can buy in independent practice that does this stuff and so it is out there. You don't have to buy the \$20,000.00 shebang but there are smaller streamlined ones that are available at lower costs for independent, individual both psychologists, social workers –

**Joe Heyman, MD – Whittier IPA**

Yes, but will they still be three hundred to five hundred dollars?

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

Yeah because some of them are Meaningful Use so they have this in there already. So, yeah, they could still be that.

**Joe Heyman, MD – Whittier IPA**

Okay.

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

And I just – I do want to reiterate that the way that we were envisioning this is that this is a modular program and that, you know, that, you know, some place like the National Association of Social Workers could say, you know, here are the core modules that are, you know, important for social workers and that, you know, that can help guide the social workers in picking a system that has everything that they do need so that if it's not relevant to their scope of practice that they wouldn't be paying for it.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, this is Paul, but the problem I perceive with that approach, because I know we had the same discussion with the LTPAC process, the problem I perceive is when you end up with a whole boatload of modules, because then after a while you shrug your shoulders and you say, well we're going to let everything be a module, then you don't have anything that you can buy or most people can buy that has a package that's got like, you know, the ONC seal that this is a totally certified product and, you know, you just have a list of modules.

I mean, I would suggest an alternative and the alternative I would suggest would be to say for the ineligible providers to focus on the issue of, you know, interoperability, connectivity, you know, the transitions of care, the communications, the privacy and security and stuff that we've done so far and say that's certification and then list out here's some other additional modules that are also certified modules that depending on your practice maybe appropriate.

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

And I think that –

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

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

It really depends on how that gets structured. I mean, I think you can do something that's kind of like a core, you know, like a core module that gets you to a certain place, but, you know, like we were talking about the variability in behavioral health provider types kind of makes that core pretty small and, you know, in reality, you know, I don't have a big preference in how it's structured ultimately but I, you know, I do hope that that type of diversity in workflows is taken into account in how the system, whatever system gets set up is set up.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and this is Paul, my view is it's okay if it's small because these people don't have any money number one and number two is we're not giving them any, you know, we're not doing anything to help anybody buy the –

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

Yeah, that's true.

**Paul Egerman – Businessman/Software Entrepreneur**

And so –

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

Well that's a whole other –

**Paul Egerman – Businessman/Software Entrepreneur**

We're not giving them any help –

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

That's a different problem.

**Paul Egerman – Businessman/Software Entrepreneur**

And they need the help and so small might be very good, it might accomplish something that helps, maybe it's a baby step forward but I don't think so, I think if you got it so that people could, you know, receive and transmit information that would be a good step forward.

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

I agree with you on that Paul, I mean, that's the yeoman's list here because if you're going to be interoperable then you've got to use the same standards, code sets, everything that's in the C-CDA, you've got to build the infrastructure within your EHR to manage all that so that's the biggest lift.

I'll move on from my issues with the clinical decision support, I mean, as long as it's a module then fine and maybe it doesn't need to be tied to Meaningful Use, but I think we're doing a disservice if people don't know that it is or it isn't because they're going to be buying stuff that – they don't have enough resources to know what they don't know and that's what we find –

**Paul Egerman – Businessman/Software Entrepreneur**

Yes I would call this an optional module or an optional certification but I wouldn't include it as –

**Joe Heyman, MD – Whittier IPA**

But it's all optional.

**Paul Egerman – Businessman/Software Entrepreneur**

Well it's all optional but I would like all the other pieces the privacy and security, the connectivity piece that's actually packaged that one could get certified for.

**Joe Heyman, MD – Whittier IPA**

I agree with that.

**Paul Egerman – Businessman/Software Entrepreneur**

Because that could be valuable.

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

Yes.

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

Yeah, yeah I think that's the first one, absolutely.

**Paul Egerman – Businessman/Software Entrepreneur**

So even though that's small it doesn't change – I mean, the real key there is you don't do anything that really has any major impact on workflow, I mean, you've got to have coding standards and stuff, but, you know, you don't end up with any kind of clinical decision support and the same thing is going to be true of ePrescribing because a lot of these – and the social workers don't order medications is my guess.

**Joe Heyman, MD – Whittier IPA**

Right.

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

Right, I agree with that.

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

And before –

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

Okay, I'm good.

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

Okay and this is Sue and before I move off can I just ask real quick under the umbrella, if you would, for clinical decision support there is a separate citation number for the drug-drug, drug-allergy interaction checks and that is not showing up on the slide deck, so is that a conscious decision to not include the drug-drug, drug-allergy checks?

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

Yes and that's because, you know, so many – so we included that in the prescriber module that we will call out in a couple of minutes, because, you know, the majority of behavioral or ineligible provider are not prescribers.

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

Okay, I just was wondering if that rule was still hanging around someplace, so thank you very much for that.

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

Okay, so to recap this, this is pulling out the certification criteria for clinical decision support, we've discussed how that's in place because Meaningful Users need to do that as one of their MU objectives.

Mike and others have pointed out that for providers who are participating in an ACO and various managed care programs you often are asked to implement decision support activity and if you're on the same base as the eligible providers you should be able, hopefully, to actually do that recognizing that there are a million twists and turns that could make that not true but at least the odds are stacked in your favor. And again, that this is modular.

So, the complication I heard that I think we should focus on and either address or decide not to address is the decision support criteria are pretty broad in that you can pull the rules from a variety of things including labs and it was suggested that it would be unlikely that many of the behavioral health providers would have lab results and would we be asking to take on an unnecessary burden or their vendors to take on unnecessary burden build a reference lab data if they would never have lab data as opposed to creating a wrinkle in the certification criteria to allow for either more granularity or optionality among the elements discussed.

So, a long ramble, so any thoughts about if we want to sort of open the seal on an existing criteria, certification criteria?

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

You know this is – maybe it's in the way once it's done it gets – how does it get presented? Like, I remember if you go to the ONC site where you have certified products and I know I haven't been there recently but when they first came up on the left hand side you had those little boxes and it said, we passed this, we passed this, we passed this.

So, if we did the same thing and then a vendor said, hey, I don't include vital signs for social workers, I don't include vital signs for my social workers, it's not – they don't have a check box on that, then the provider would have a very clear understanding of what it does and doesn't do.

So, maybe it gets down to that level and we have to make sure that once the certification is done I think you allow everything in sync to be certified but the vendor can say, for the practices I sell to you guys don't do this so I'm not certified for that, your cost is cheaper because I don't have to build it and I think that might help.

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

So, to be fair to your statement and not short circuit it, what is listed is really at the level of what's in our middle column here?

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

Yes.

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

It lists the broad category that's being used, it doesn't identify what's in that.

**Joe Heyman, MD – Whittier IPA**

This is Joe, I think I'm opposed to including clinical decision support as a certification requirement. I'm not opposed to having them have clinical decision support but I don't think it needs to be a certification requirement.

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

You mean a separate module?

**Joe Heyman, MD – Whittier IPA**

Yeah, I don't think that it – I just don't think – I think it's making it too complicated for a huge portion of behavioral health people. I just don't think it's necessary and I think it's hard to expect vendors to list every single part of a medical record that is included or isn't included. So, I –

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

Now I don't think it would be every –

**Joe Heyman, MD – Whittier IPA**

So, I think it would simplify it a lot if we just didn't require it.

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

So, I think, you know, I want to pick up on two things I'm hearing Joe and some of the things that have been discussed earlier.

So, I think this notion that some of the criteria fall into some kind of core set of criteria, ONC has used the term in the past base-EHR but we're talking something smaller than the base-EHR so I'm not quite sure what the terminology should be, but there is some set of things –

**Paul Eggerman – Businessman/Software Entrepreneur**

Based on interoperability.

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

That support interoperability, privacy/security that group of things. And then there are other things like clinical decision support that may be of value to some providers and not of value to others and is currently a modular criteria and I think what we're reporting back on these things is these are things that we heard are of value to some providers in this care setting and that our assessment is that the current criteria do or don't meet them, meet their need and I think that's about as far as we're going.

We're not creating a behavioral health certification program at least that's my sense from all of our discussion we're not creating an LTPAC certification program. We're supporting the extension to these other providers of these programs we're identifying some core things that look like they're of value or identifying some issues with the existing criteria as they apply in these settings. Am I off base in what I'm saying here guys?

**Joe Heyman, MD – Whittier IPA**

I would have to ask the ONC people that because it sounded to me all along like we were specifically setting up a certification program for long-term care and behavioral health now maybe I just misunderstood.

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

This is Mike; I didn't think we were setting up a full certification, I felt we were setting up that these modules, if you use these modules, those modules get certified and then you use which pieces you want to buy that are important to you as a provider.

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

Hi, this is Elise from ONC, Mike you're on the right track. The goal from ONC's perspective is to understand what are really the core pieces that are important to BH and to LTPAC sector and then taking that into consideration figuring out ways to have criteria that are certified to accomplish those goals, you can kind of think about it in terms of buckets like what is the bucket that would work best for BH and what would be the bucket that would work best for LTPAC.

In terms of the creation of a comprehensive certification program that would be, for lack of a better word, let's say, MU-sized would not be the goal in terms of what the charge is.

The charge is really to isolate those things that are so crucial to BH and LTPAC Health IT and the Workgroup seems to be going along the lines of interoperability and transitions of care, care coordination, but to have those as buckets that could be used, could be developed by vendors in a non-MU capacity for the benefit of those particular settings. Does that provide some clarification?

**Joe Heyman, MD – Whittier IPA**

So they would be certified, the core things would be certified as a product, no?

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

Well, right, the criteria. We would set up the ability for the criteria to be certified and then vendors could say that they are certified to this transitions of care module for example or this interoperability module and then could be marketed by the vendor as applicable to the LTPAC setting or the BH setting and there may – and I think this came up on the earlier call with LTPAC, it could be that the transitions of care, let's say bucket, is also applicable to BH.

So, it's not necessarily an LTPAC transitions of care or BH transitions of care. Now all of this would have to be worked out with our kind of regulatory team, but these are the ideas that spark the initial conversation and led to the charge to the Workgroup.

**Paul Egerman – Businessman/Software Entrepreneur**

If I heard you right, this is Paul, I just want to make sure, you want things that are essential to behavioral health, did you use the word "essential?"

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

Well, I think you can use the word essential but are important to. I wouldn't necessarily –

**Joe Heyman, MD – Whittier IPA**

Important to?

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

Because I think that's for the Workgroup to decide what does the Workgroup deem are most important to this sector and I think that's the benefit of the hearing as well from ONC's perspective is to be able to hear what is important to the sector. So, I would say what is important to the sector in order for them to achieve Health IT capacity.

**Joe Heyman, MD – Whittier IPA**

Well, there's a different between essential, most important and important and nice to have, and I guess I'm looking at this clinical decision support as something that's nice to have.

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

And I think that would be for the Workgroup to decide.

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and this is Paul, I agree –

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

Yeah it depends on the –

**Paul Egerman – Businessman/Software Entrepreneur**

I agree with what you're saying Joe because this is also like the starting point.

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

It depends on the –

**Paul Egerman – Businessman/Software Entrepreneur**

And even if you don't – you know, I mean there is always a chance to add stuff later.

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

Well we're not prohibiting people from certifying to any of the MU criteria.

**Paul Egerman – Businessman/Software Entrepreneur**

– right.

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

Any of the existing certification criteria.

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

Right, I mean –

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

That's the way it exists today.

**Paul Egerman – Businessman/Software Entrepreneur**

–

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

And we have examples of vendors who –

**Paul Egerman – Businessman/Software Entrepreneur**

On this issue I don't feel like really confident, because I don't have a good understanding of like what happens for psychologists and social workers but nothing I've heard says to me this is something that most of them really have to have and –

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

Yeah, it depends on your setting, if you're an independent private practitioner, no you don't need this. If you're a small licensed facility you do need it because then a lot of your licensure makes you do this kind of stuff. So, I think making that distinction may help, small independent private practitioners no you probably don't need this, it's not essential.

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

And that might go, this is Elise again, that might go to Maureen's earlier point in terms of thinking about this in terms of modules, it wouldn't be kind of, you know, everything into one bucket per se.

So, if it's the case that the Workgroup thinks that this is helpful for some BH settings and not for others that could be noted and it could be noted that this, you know, if it stands alone as a bucket then it could be applicable where vendors decide to develop it as such or where providers request it as such.

**Paul Egerman – Businessman/Software Entrepreneur**

The only other observation I would make is there is a lot expense associated with this, the clinical decision support is a complicated piece of software, so this by itself adds a lot of expense to whatever you buy.

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

So, I guess I'm hearing this is a specific one where we want a shaded recommendation here that there is some providers, to Mike's point, where this is very important but others where it's not important –

**Paul Egerman – Businessman/Software Entrepreneur**

And I think that's a good expression Larry. We don't have to be unanimous on everything. Joe said he was opposed, I have reservations and so you can say there was not unanimity on this there was a range of views.

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

And that's – I think that's a fine resolution of it.

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

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

For ONC to know what we thought.

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

Yeah, I'm good with that.

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

Okay, can we resolve that one this way?

**Joe Heyman, MD – Whittier IPA**

Yes.

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

Take a swing around the room?

**Joe Heyman, MD – Whittier IPA**

Joe says, yes.

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

Liz says, yes.

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

Mike says, yes.

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

Maureen says, yes.

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

John Derr says, yes.

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

Joan says, yes.

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

Jennie agrees there is lack of consensus.

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

Good one.

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

Thank you Jennie we needed a sense of humor here. Okay, so I've got a question on timing, the next one is clinical quality measures and I expect – well –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, I think –

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

The recommendation is future work, so does that make this an easy one for us to discuss in five minutes?

**Paul Eggerman – Businessman/Software Entrepreneur**

Well, this is Paul, maybe, I have to tell you I'm actually opposed to this one the reason is it's a variation of what Joe said earlier when we were talking about – talking about transitions of care he said people have to give a damn and the same is true of quality measures.

I mean, just producing a quality measure or a quality report by itself does not improve quality and it seems like we have literally thousands of these reports now but the quantity of quality measures is not by itself going to improve quality.

So, with this – I read this I say, oh, you're going to put together some committee and they're going to sit around and they're going to come up with a whole boatload of quality reports and that's what these guys always do, they always do it and I don't know, I mean, it's like you're talking like substance abuse it's got to be like reports, quality reports for abuse because people can't stop themselves from producing these reports and I just hate to make this recommendation for more reports that's my two cents.

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

Yeah and this is Mike. I'm split the same way, if you're an independent private practitioner, no you probably don't use it but I know all my members who are larger organizations don't have psychiatrist they're made up of psychologists and social workers they work in coordinated care settings they have to do this stuff, a lot of their reimbursements, payments, Medicaid audits are tied into clinical quality measures so it's important to that sector.

**Paul Eggerman – Businessman/Software Entrepreneur**

But then they have the mandatory things they have to do is my guess.

**Joe Heyman, MD – Whittier IPA**

Right.

**Paul Eggerman – Businessman/Software Entrepreneur**

And they have a few things that they themselves want to do but I don't know that we need to add something more to their list.

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

Well, I would just say if they're going to – if they're going to buy a product and they know that "hey it does these things" they can then buy that module. And again, as a modular approach I would see this as a module that someone could or could not purchase depending on their practice.

**Joe Heyman, MD – Whittier IPA**

Well this is Joe and I would just say I'm sort of on the side of being against it but if we are going to recommend it then it's extremely important to put way up front that it must not interfere with the workflow, that we can't have extra steps added in order to do these measures.

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

I'm – that's fine by me, I like that wording actually.

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

And I hope that the Quality Workgroup, Quality Measure Workgroup would certainly take that into account and –

**Joe Heyman, MD – Whittier IPA**

Well, I would argue that they haven't done it very well up until now.

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

Well, there's always a first time.

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

Yeah, we – yeah, I'll have to work on that because I'm on that Behavioral Health Workgroup at NQF. So, I'll talk about that more as it comes up.

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

This Workgroup though is the Health IT Policy Committee Quality Measures Workgroup.

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

Oh, okay, I'm sorry.

**Joe Heyman, MD – Whittier IPA**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah it's created what's called the new generation of quality measures.

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

So, I actually agree with this recommendation and the referral to the Quality Measure Workgroup and I think in this – if we advance the recommendation to them I think the importance of considering quality measures that fit within the workflow is paramount and we should make that clear to them.

**Joe Heyman, MD – Whittier IPA**

But I also think then it's also very important that there be quality measures that are actually important to the social worker for example.

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

Yes.

**Joe Heyman, MD – Whittier IPA**

And her person, and her client rather than some general quality measures that somebody thinks is important in general and has nothing to do with what a social worker does.

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

I agree.

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

Yes.

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

And this is John Derr and I would recommend – I echo everyone else because this is one of the areas I've been trying to work in and it's a piling on thing and most quality measures are penalty oriented rather than quality of care oriented.

So, I would recommend that when we do these, and they have to be eQuality measures too not just quality measures, that we look at things in a more realistic on patient care rather than the penalty that if you don't do something you're penalized.

**Joe Heyman, MD – Whittier IPA**

You won't get that from this. If there are measures and there aren't surpluses that are going to be distributed on the basis of them they'll be penalties attached to them, that there is no question about.

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

And I'd just say that really penalty management doesn't ever really get good results in the long-term.

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

Yeah, I would just want to say – I mean on the surplus thing it doesn't come directly to behavioral health providers but once you start working with new payment models and new systems well then you have the opportunity to share in the surplus with those like the hospital who is saving a ton of money because you helped them stop re-admissions.

So, I agree it shouldn't be penalty-wise, but there are opportunities if you're on the same platforms measuring the same things as your hospital and other healthcare community partners that everybody can share I think that's where we're going and hopefully we can set things up so behavioral health can participate that way.

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

I agree.

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

Okay, so I'm going to try and get us to closure here. So, what I'm hearing is there is split on the committee in terms of the problems with existing quality measures that there are some guidelines that we're suggesting around they need to be important to the provider, they need to be within the workflow and not a "check box." They need to focus on patient quality. So, I'm hearing some of that.

I'm also hearing though that this is an area that's easy to kind of over regulate and pile on and to sort of Mike's not ONC work, right, to the NQF work, that there is work happening in quality measure organizations that ought to be built on. But that otherwise we're not saying this is something actionable in the near term.

**Joe Heyman, MD – Whittier IPA**

Well, if you can say all those things I would agree with it.

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

Okay, so having said that maybe there is agreement, maybe the agreement is tell them that the kind of quality measures are really a problem and don't dive in here with things that are not going to be helpful.

The question is going to be guys though if we're actually asking them to make a recommendation back to us we're going to be in the specifics of this down the road and I think we should actually pay attention to that now.

**Joe Heyman, MD – Whittier IPA**

When you say we'll be in the specifics do you mean that we'll be suggesting the quality measures or do you mean that we'll just be discussing the certification of somebody else's quality measure?

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

So, we'd be discussing the certification of someone else's quality measure.

**Joe Heyman, MD – Whittier IPA**

I see, I see. Well, as I said before I leaned against it.

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

Yes.

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

Is it helpful at all to send around what those NQF clinical quality measures are, the 18 that are behavioral health?

**Joe Heyman, MD – Whittier IPA**

It can't hurt.

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

All right, I'll send that out.

**Joe Heyman, MD – Whittier IPA**

I'd be interested in seeing those. It may not change my opinion, but –

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

Yeah, at least you'll see them.

**Joe Heyman, MD – Whittier IPA**

Right.

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

So, maybe I'm hearing a two-part thing then that there is general agreement about all the stuff I described about what makes a quality measure reasonable, but there is not – there is a variety of the sense of the committee on whether clinical quality measures – well, it's all modular, I don't know what I want to say.

**Joe Heyman, MD – Whittier IPA**

It should be required for a social worker.

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

It should be required, right.

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

Or a psychologist or a –

**Joe Heyman, MD – Whittier IPA**

Or a psychologist yes.

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

Professional counselor –

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

Yeah. I mean, we're going to –

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

Or marriage and family therapist.

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

Right, we're going to have it across the board.

**Joe Heyman, MD – Whittier IPA**

I was using it as an example.

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

I know.

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

Well, I'm – from it being 12:31.

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

So, is everybody on the Workgroup okay with then a representative from the Quality Measure Workgroup coming to talk to this Workgroup on a future call?

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

– future call?

**Paul Egerman – Businessman/Software Entrepreneur**

You mean to learn about the new generation?

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

Well, they have, the Quality Measure Workgroup has their transmittal letter about ready to go and so they could talk about, you know, what's in their transmittal letter and opportunities for long-term post-acute care and behavioral health as it relates to their transmittal letter, specifically as it relates to future work. So, you know, I think there could be a good conversation that comes out of that.

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

I'm happy with that.

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

Jennie is happy with that.

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

Mike is good.

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

So is Maureen.

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

Okay, thanks.

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

Okay, so we're mostly happy, amazing. So, a quick comment about next steps. So, we've got another behavioral health call coming up in a couple of weeks to make our way through the rest of these and then we've got a couple of sessions to regroup and look broadly what we're doing and I think this whole notion of a subset or core that we think are priority maybe we should call them priority areas and there are others that are setting specific issues that we've heard a lot of interest in.

And then there is broad range of things that we'll see what the marketplace decides as vendors do or don't implement various modules for use in these sectors. So, with that I think we're ready to open up for public comment.

## **Public Comment**

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

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

**Rebecca Armendariz – Project Coordinator – 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're 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 – Senior Consulting Architect – Kindred Healthcare**

Well, I'd like to thank everybody for their time, attention and the discussion today. We'll catch up again on February 14<sup>th</sup> Valentine's Day.

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

Thank you.

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

Thanks everyone.

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

Thanks everyone.

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

Bye, have a nice weekend.

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

All right, bye-bye.

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

Bye.

**Public Comment Received**

1. This is how we have tried to handle some of this. Our HIE consent form: PERMISSION TO SHARE MY HEALTH INFORMATION WITH WELLPORT1) I have read and understand "Giving Permission to Share Your Health Information with Wellport".2) I release any and all of my personal health information (including information I might consider sensitive) from any participating health care provider delivering my health care for the purpose of creating my Clinical Health Summary and Personal Health Summary.3) Please answer YES (by initialing) to indicate your permission to release the information below (if it is in your medical record):ALL MUST BE INITIALED TO PARTICIPATE\_\_\_\_\_ HIV test results and other information about sexually transmitted diseases\_\_\_\_\_ Genetic Screening test results\_\_\_\_\_ Reproductive health concerns and any pregnancy history including abortion\_\_\_\_\_ Alcohol and Drug Abuse Records\_\_\_\_\_ Details of Mental Health Diagnosis and/or Treatment\_\_\_\_\_