

**HIT Policy Committee
Certification & Adoption Workgroup
Transcript
October 25, 2013**

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

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

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Larry Wolf?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Joan Ash? John Derr?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Carl Dvorak? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Joe Heyman? George Hripcsak?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Stan Huff?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Liz Johnson? Charles Kennedy? Donald Rucker? Paul Tang? Micky Tripathi? Are there any ONC staff members on the line?

Elizabeth Palena-Hall – Office of the National Coordinator

This is Liz.

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

Hey, Michelle, it's Elise.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Hi Liz and Elise. Anyone else? I think Jen Frazier should be on the line, she should be on VIP, so she is on the line as well. And with that I will turn it back to you Larry. Larry one thing I just – could you introduce John Derr and Stan Huff because they've been added to the group too?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Sure.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I forgot to.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I'll say a quick word of hello and maybe John and Stan would like to add a couple of comments. We were looking to coordinate what we are doing here with the work of the Health IT Standards Committee and we wanted to more accurately engage a couple of specific members of that committee rather than kind of throwing it open to – and the whole of the Workgroup there. So, we specifically brought in Stan and John they've both been long-standing members of the Standards Committee and also they have specific interest in the areas that we're looking at.

Stan has a very long standing active role in standards and John has been very active with the long-term post acute care community and both those points-of-view I think will be really important so the work will be out in front of us. So, a short welcome to them and Stan or John if you would like to say a few words of introduction that would be great as well.

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

This is John, you covered it pretty well, Larry. One of the other things I'm a number – I'm on the NQF's HITECH Committee and on a couple of the other Workgroups like Implementation and Patient Engagement so I cross over a lot of the different Workgroups and trying to represent long-term post acute care and this group is very important to us to get the voluntary certification so we can go to our vendors and to our providers and give them more specific direction on how to be an active member of this whole new healthcare system.

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

Larry, this is Stan, it's a pleasure to be here. I apologize today I'm going to have to leave in about 40 minutes to catch a plane, but I'm excited to participate and look forward to the discussion.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, well thank you very much for joining us and look forward to your participation. Maybe we can drum up some of the other members of the Workgroup as well since we've got some of the new folks and some of the old folks back to demonstrate that this is an important topic for us to be looking at. So, maybe we should bring up the agenda slide. I'm sorry if I'm out of sync with the presentation, where is my presentation, there it is, thank you.

So, we have a new job in front of us to look at voluntary certification. So, way back once upon a time we helped frame the required certification as part of HITECH and since then there has been a lot of discussion about how do we extend the structure of certification and the value of certification to other areas and what might be those areas and so ONC and the Policy Committee have asked us to really look at this in a couple of different ways.

So, one piece is to look at this broadly as what is the value of voluntary certification, what factors should we consider in looking to frame a voluntary certification program or programs. And then there were some specifics that have come up looking at a couple of key settings so both long-term post acute care as a setting and behavioral health as a setting.

Those providers in general are ineligible for the HITECH Meaningful Use Incentive Program but there is a desire to, because of issues of, you know, continuity of care, trying to be patient centered and actually provide similar tools across care settings so that information can follow the individual as they go from care setting to care setting, that there is value in these care settings for extending certification but there is no legal mandate to do that.

There is no regulatory mandate and what can be done, if you will, with government as convener or perhaps government as accelerator to help with voluntary standards in certification in both of those care settings.

And so in terms of the overall structure of the Workgroup we are going to be looking at all of that. We are going to begin by talking about voluntary certification as a general piece and then we are going to look at the issues in those two specific areas. So, are we good with overviews guys?

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

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, silence is consent.

Paul Egerman – Businessman/Software Entrepreneur

Larry?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes?

Paul Egerman – Businessman/Software Entrepreneur

Larry, this is Paul Egerman, could you just define what you mean when you say voluntary certification?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, I think we're going to get into that Paul.

Paul Egerman – Businessman/Software Entrepreneur

Okay, good.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

ONC has put together some slides for us as discussion points and so let me do some mechanics first. Well, actually I was going to run through timelines first but I see that the slides have us talk about exactly the charge. So, why don't we go onto the next slide we'll talk about the charge and then we'll explore Paul's question as well. So, voluntary certification, the charge.

So, we're being asked to recommend a process for prioritizing Health IT capabilities. So, under HITECH Meaningful Use is the driver for certification, right? Certification is in support of the Meaningful Use objectives and so that what's been used to frame up what needs to be certified and in some ways to define the scope and the depth of the certification process and the testing that goes with it. So, in a setting where we don't have that kind of driver what would be the process for prioritizing Health IT capabilities?

And second how would previously adopted certification criterion standards tie into the needs within the care setting? So, the first one is prioritization relative to interoperability and the second one is prioritization relative to needs within the care setting. So, this notion of, as one of my buddies likes to say, before we can interoperate we have to operate so what technology is in place in each of the care settings and what is available for sharing information across care settings.

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

Larry, this is John?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes?

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

I just, in my little introduction, I wanted also to say that, you know, a few years ago, 2 or 3 years ago, as a volunteer effort we worked, the long-term post acute care sector worked with CCHIT to develop a set of standards for criteria for volunteer certification and came up with a set for nursing homes, skilled nursing facilities and home care. And I just wanted the Workgroup to know this if they didn't know it already and that a number of vendors have done it.

So, the word volunteer, at least to us, or at least to the people I talk to means that we would do it and I think this sector LTPAC stands ready to do that both on the provider and the vendor side, but they need a little bit more stronger direction which would come from this group, but they are willing to volunteer to do it because they want to interconnect and have interoperability with hospitals and the professionals.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And picking up on John's note, in addition to the LTPAC, CCHIT also created behavioral health criteria.

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

Correct, yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, there is a long-standing interest from both of these care settings to have certification criteria and to get their vendors to head in that direction. So, let's talk about the charge. So, thoughts, comments, reactions? Paul you already sort of raised the question about what do we mean by voluntary certification.

Paul Egerman – Businessman/Software Entrepreneur

Yes, the reason I raised that though is when you were speaking Larry I think a couple of times you talked about using the word mandatory and regulations, but if you think about certification process I think a lot of the certification process is misunderstood, but certification is one of two things that a provider, an eligible provider or an eligible hospital must do in order to get an incentive or to avoid a penalty from, basically from CMS.

And the entire program is voluntary, by that I mean, you know, physicians and hospitals if they choose to, they don't have to participate, I mean, they don't get the incentives and they may get a disincentive in a future year, but they don't have to participate and the same is true of software vendors.

I mean, if I wanted to I could create a computerized EHR system and shrug my shoulders and say "I don't want to mess with that certification thing and I'm going to go ahead and sell this thing anyway." And I could sell it, again the people who would purchase it wouldn't be able to qualify for the Medicare incentives or, you know, the incentives that are in the programs, but not everybody does.

And my point here is our process right now still is a voluntary optional process with certification it's just that there are some very strong incentives attached to it. So, we seem to be talking about expanding that to some other voluntary process that perhaps is not attached to the incentives.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, Paul, I think that's a really good point. We often lose sight of the fact that, as you stated, the whole thing is voluntary. There are penalties and incentives but they're not – you can't practice medicine, although in some states you might think they are trying to head in that direction.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, it's not like – I mean, the contrast I'll give you is you look at like FDA. FDA regulations are, you know, if I say it's an FDA regulated device I simply cannot sell it without FDA approval, at least I cannot do it, right? And healthcare organizations I think probably cannot buy it. And, you know, this is very different and everybody sort of takes it for granted that this is mandatory, because almost everybody is doing it but it is not mandatory.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, it's a good point. Maybe we should also then noodle on the language, because this has been done – the labeling of this voluntary is really to expand the audience if you will and, you know, it also could be argued that we already have examples of lots of voluntary aspects particularly around modular certification where vendors have chosen to just have pieces of applications certified because their customers and their functionality only align with those criteria. And we've even seen that for vendors who are not selling to eligible providers.

Paul Egerman – Businessman/Software Entrepreneur

And as part of the voluntary process the other observation I'd make is you mentioned modular certification. If I'm a vendor I could get a module certified and I might still sell it to some organization like an extended care facility who might not qualify for Meaningful Use, but find value in having a certified module.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's correct and we see examples of that.

Joe Heyman, MD – Whittier IPA

Did you just ask for examples Larry?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

No we do see examples of that, but –

Joe Heyman, MD – Whittier IPA

Oh, okay. This is Joe, I just don't – and maybe because I missed you reading the charge, but when I looked at the slides I don't understand the difference between these potential applications and the applications we have right now. What is the difference?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I think the difference here is the existing process has the driver of Meaningful Use requirements, Meaningful Use objectives and those objectives then set the framework for certification criteria and they're tied around the Meaningful Use Incentive Program. So, maybe the optionality here is or the mandatory here is if you're going to be involved with the Meaningful Use incentives then you need to have certified EHR technology so it's not optional in that sense.

Joe Heyman, MD – Whittier IPA

But what is the new application? I mean, they're asking for some different program from the one we have now and what I can't understand is what they're expecting the new applications to be that are different from the current program? I mean is it that they are not going to qualify for Meaningful Use? And if so, why do they need to be certified at all?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, that in fact is I think a piece of the question. If there isn't a program like Meaningful Use or like the – exemption that by regulation or by law says you have to have certified EHR technology and why would anybody want to have certified EHR technology? And I can give you an example that is relevant to Kindred because I'm living with this, and that is we're looking to implement systems that will support acute care systems that are sending us their electronic patient summaries as part of their discharge process and to help them fulfill their Meaningful Use 2 requirements.

So, I go to vendors and say "I want to be able to receive standards-based information and it increases my level of confidence in you if you've been through the certification process and can tell me that you have modular certification to receive those and also to be able to send care summaries."

Joe Heyman, MD – Whittier IPA

But there again you're using something that will satisfy a Meaningful Use requirement.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It's Meaningful Use to the acute care hospital but it's not Meaningful Use to the post acute provider who is acquiring the software.

Joe Heyman, MD – Whittier IPA

I see. Well, I guess as a provider my feeling was when they first started the program that providers needed confidence that there were certain EMRs that worked well, now there is, you know, KLAS and so many other, and so much EMR adoption that I don't think certification is giving anybody extra confidence. People know which the EMRs are that are commonly used and they adopt them on the basis of competition and features.

As far as I can see why – I guess what I'm thinking is you would have to develop new certification criteria for new applications before anybody would try to be certified and so what different criteria would you require that's "a" and "b" one of the things that's been a result of Meaningful Use is that it's sucked all the energy out of the innovation room when it comes to EMRs and my concern would be now you're taking other products and pushing them into –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I hear that. So, let me put this conversation on hold for a couple of minutes so we can walk through some of the framework that we've got here as what the game plan is –

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

Could I ask a different question?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And then come back to this discussion, because I don't want to lose it. Go ahead.

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

Joe, could I ask – hi, this is Stan Huff, just to make sure I'm understanding when they say prioritizing Health IT capabilities, I mean, are they talking about the things that I would normally think of as result, review and order entry, and scheduling, and sharing of care summaries and care plans. Is that the kind of capability – are those examples of the capabilities that they are thinking need to be prioritized?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, they could be and many of those are already included in the Meaningful Use related Certification Program, but there might be other requirements in a care setting. So, for example, nursing facilities, skilled nursing facilities, home health agencies have mandated assessments that need to be completed and so if you were going to have an electronic health record you would want that health record system to be able to complete those assessments.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and this is Paul, I looked at this – when I saw the word "improve interoperability across a greater number of care settings" perhaps wrongly, I assumed that was a – I inferred from that that we are really talking about prioritizing like information exchange capabilities and make it possible for EHR systems to communicate with extended care facilities or perhaps other things, you know, physical therapy groups or DME –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

Organizations that are not really involved with the entire process but would be – the EHR process directly, but, you know, might be organizations that routinely hospitals and providers would interact with.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I think we are actually being asked to do two things. We're being asked to look at criteria around interoperability and criteria around functions within a care setting.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, the slide two, which is what is up, has the two bullets and the first one addresses interoperability and the second one addresses more broadly or maybe less broadly needs within a care setting. Okay, let's take a walk through sort of timelines and continue to tee up this discussion, because the plan here was to start a discussion and then to pick it up at our next meeting. So, let's continue to walk through the structure here. So, let's go onto the next slide.

So, looking now at the framework that we've been asked to work with the first part is to look at this big question, right? If you're going to have – if you're going to extend the certification program and I'll continue to use voluntary but I think we may need to figure out how to nuance this a little bit. How would you go ahead identifying the criteria?

And then secondarily or not secondarily but then part two would be we have two specific care settings – broadly-based care settings, long-term post acute care and behavioral health that as we began the call we noted that they have already gotten, you know, once upon a time when CCHIT was the only game in town they work with CCHIT to create certification criteria for their care settings and there have been some vendors that did go through CCHIT certification against that criteria sort of in the early days prior to the full blossoming of the Meaningful Use Programs.

So, step one sets up a framework, step two would then, if you will apply that framework in this payer of care settings and then I actually proposed that there is a step after we do step two we would revisit what we learned in step one to see if it actually played out well and update whatever we did in step one based on our experience in step two. So, let's go onto the next slide.

So, this is laying out things we've already talked about that this Workgroup is going to develop some recommendations that we are going to coordinate it with the Standards Committee and have brought John and Stan on to help with that. And we expect there will be a good role for S&I Framework in this because in fact that has been a venue in which a lot of work has been done, people have gotten together to operationalize standards to flush out even directions and to define a lot of work.

And the timeline here is to get all of this done by March of this coming year and while there is no specific regulatory timeline here I think the desire from ONC was that this should be vaguely in the timeline of Meaningful Use Stage 3. Let's go onto the next slide.

So, we've scheduled several meetings which I think you guys already have invitations to for your calendars. So, the first one is today, which is what we're doing which is an overview of the charge, a discussion that we've been having about voluntary certification and then to continue that on the next call on November 4th and then after that to start to look at what's happening in the long-term post acute care space, and then to look at what's happening in behavioral health.

So, there are three planned sessions on LTPAC and we're expecting to bring in some other participants so it will be similar to a hearing but more interactive and acting more as an extended invitee to the Workgroup. Next slide, please.

And then we'll wrap up the three sessions on behavioral health, we'll have some time to draft some recommendations to the Policy Committee and then present those in February with a second round of feedback and update, and final recommendations in March, and then parallel recommendations going to the Standards Committee later in March. Next slide.

Okay, so today's goal is to start on step one and why don't we just quickly flip through the slides so we've had a chance to see them all. So, next slide and we'll walk through some factors for evaluating what's needed. Next slide.

And look at this notion of a well-defined health improvement need. Next slide. What we know about adoption and interoperability. Next slide. Where this might tie into existing federal and state programs. Next slide. Where there are things that are needed in advance such as, you know, maybe there is a missing standard or maybe there are competing standards and we need to decide. Next slide.

What is sort of the – what do the stakeholders think of this and where are they asking for help and where do we think we can be helpful? Next slide. And then some existing resources that are out there from both ONC and ASPE. Okay, so let's back up, I think it was slide 5, let me check on my deck. Sorry, slide 7. Okay –

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

So, Larry, does it make sense to elicit from this group their thinking on that first question, would a, whether it's voluntary, I agree with what Paul said that's probably a bad term, but whether this has benefits for Health IT of these ineligible providers. I mean, is what we're doing have value I guess?

Joe Heyman, MD – Whittier IPA

I still don't understand what we're doing. I don't understand the difference – what the thrust of this is, maybe it's just me.

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

Well there are certain groups –

Joe Heyman, MD – Whittier IPA

I can't see the slide.

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

Yeah, I mean, in a nutshell – this is Marc Probst, yeah there are certain groups that currently do not receive Meaningful Use dollars, you know, for implementing electronic medical records, so you know what we're doing overall on the Meaningful Use?

Joe Heyman, MD – Whittier IPA

Right, right.

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

And the question is if we enhanced the – if we just had some additional certification requirements that said a long-term care facility could have certification requirements on how the technology would connect and share the medical record and Larry you are going to have to jump in and save me from this, but, you know –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

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

How we can create those voluntary requirements where they could come in and say “yeah we would do these things” or the organizations would say, the technologist would say, “you know, we will subscribe to this set of certification requirements or standards” we could improve the sharing of medical information.

Joe Heyman, MD – Whittier IPA

So, but this is Joe, so I'm implementing a health information exchange in my little community and I've gone to talk to the long-term care people and they are using a long-term care medical record and they can produce a CDA and that's all we need. And I just don't understand – I mean, I suppose that company that produces their record could go for certification because they produce a CDA, but I just don't see the point of it.

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

This is Stan Huff, you know, I had some of the same questions you did but the way I'm formulating it in my head now is that the current Meaningful Use criteria were created assuming basically acute care hospitals and eligible physicians and I think what our job really is, is to say, oh, are those requirements the same things that would serve the best needs of, you know, the longer term and behavioral health initiatives.

It's really a question of saying, you know, that the criteria that exist now were specifically about, if you will, kind of the high volume healthcare that we're providing in hospitals and in physician's offices and I think this is now saying, we've got a chance to look and say is there something more, different kinds of transactions maybe around rehabilitation, other capabilities in the system that would be important in those care settings that weren't considered during the consideration of the Meaningful Use criteria.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul, as I'm listening to this and a couple of comments, one is to sort of pick up on what both Joe and Marc said, I can see where there would be value in having say an extended care facility be able to use software that was tested against some standards about say exchanging a CDA or exchanging other information and I could see there would be value in having say a commercial laboratory be able to have software that was tested against some standards about exchanging laboratory information. So, that part makes sense to me.

The part that I don't – and to accomplish that what you would sort of do is take our – part of the process would be to look at our existing testing and certification process and find ways to sort of chunk it up or chop it up or something into modules small enough that they would be useful.

The part that causes me to pause is when we start thinking about some of these organizations that currently aren't, you know, eligible for Meaningful Use whether or not we should be writing – whether or not the government should be writing certification criteria for how they do their health information technology because I'm not sure why the government is doing that.

Joe Heyman, MD – Whittier IPA

And this is Joe; I mean most of these Meaningful Use standards haven't improved anything. The only thing that they are making capable is being able to transfer a patient from one place to another and have that information be available, that is really meaningful, but the rest of it is a lot of busy work that a lot of people are doing and it's making everything look the same and I just don't – I don't see why we would want to impose that now on a whole bunch of other people who are part of the healthcare system.

I think if we want to impose on them that they have to be able to communicate, you know, I can understand that, I think that's really valuable –

Paul Egerman – Businessman/Software Entrepreneur

And Joe, I don't think we're talking about imposing it, we're talking about creating some voluntary standards and I think the communication – what you call communication I think that's where there could be a lot of value. I agree with that part. I just want to make the observation no matter what there is no vehicle here to impose anything on anybody.

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

This is John Derr and, you know, I was CIO of a 3 billion dollar LTPAC Company that had, you know, 300 nursing homes and assisted living or home and hospice care and our issue sitting on that side of the fence was that we go to hospitals to form our partnerships and they'll say to us, can you really have interoperability and connectivity with us and a lot of nursing homes I think, the one I work for has one capability, and Larry works for another large one, that says, yes but there are a lot of mom and pops out there that really don't of 16,000 nursing homes and a lot of home care agencies that don't really know what to do at this point in time and I think some of them, especially in rural areas will go under because they're putting demands on us to be inter-connective and then of course we have to send information back to a hospital when we have re-admissions, which we don't want to do but some of them we have to do re-admissions and don't forget 40-60% of the discharges from hospitals go to either a nursing home, skilled nursing home or to a home care agency and what –

Because I've been the big advocate of this volunteer because we – and when we talk about volunteer I think when you get paid by Medicare, which is the basic LTPAC is mostly paid by Medicare and Medicaid it doesn't become voluntary because Medicare says you have to have all these things and what we wanted to do – we didn't want to have a government mandate given to us from CMS, which usually happens to our market segment, i.e., the fact that medications have to be reviewed once a month and we didn't get any money to do that.

And we acknowledge that we're not part of the HITECH Act and we don't get incentives and instead of just saying, well, we're not going to cooperate at all, we said we want to cooperate and we want to play when Secretary Thompson did this whole thing and I worked with Brailer he said "well you're number three John" and at the time I was COO of American Healthcare Association and I said "well, we don't like being number three because we want to play too" and he said "well, you're priority number three" and then when the HITC Act came out we weren't included at all.

And if you're going to do a complete person centric electronic longitudinal care type of system you've got to have all care providers involved, especially in the Medicare area that are talking the same language and I think that's the key for us, maybe we're asking for it and maybe you guys don't want to give it, but, you know, one example I use a lot is you guys do a hip, a hospital does a hip replacement, we get a hip replacement therapy plan, when we get the patient we find out they have diabetes, they have congestive heart failure and a number of other co-morbidities and chronic care.

We then take that one care plan and we integrate it into a complete longitudinal plan that handles chronic care not just a hip replacement, and then many times we'll get a case manager come into our nursing home and say "where's my hip replacement therapy plan" we say "well, it's been incorporated into a longitudinal plan" and they say "well, no we want you to do exactly what we say." Well, we can't do that because the patient has comorbidities to them and we're doing their first longitudinal care plan and that.

So, it set up an adversarial sometimes, a relationship between the two caregivers and we see people, you know, months and years, and a hospital does it 3.5 days. So, maybe we shouldn't want to volunteer but we said to ourselves we want to do this to help out the whole system. And we shouldn't do more than what's necessary and, as I think Joe or Paul said, you know, if you can do a CDA what more do you want to have done?

Well, if a CDA, which a lot of the vendors can do now, is sufficient then maybe that's what we should say, but I think this group has to address it because if we don't address it and come up with conclusions then it just is left out there in the vapor world and since we're an important part of the care system I think we have to be specific, and maybe I've talked too much, sorry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

– your notion about the specific jobs and offer a suggestion –

Joe Heyman, MD – Whittier IPA

Can I just ask John a question? John, you mentioned early on in your discussion there that you were concerned about the smaller more rural places because they might go under and then you made a plea that sounded to me like you were asking for additional criteria from the government for these EMRs and it just seems to me that there is some incongruity there because if you get more requirements than that's going to mean more opportunities for regulation and it's also going to mean that the EMRs become more expensive.

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

Well, I didn't mean – I don't want – what I don't want is the government and I guess we're the government in this context, but I don't want CMS to mandate certain things because, all due respect to CMS, they're usually wrong.

Where this group understands the hospital because we're all operators and that we could do volunteer things and CMS would say, okay, that's good enough we're not going to give you government forced mandates that would force the higher cost of everything as you just stated.

So, I guess maybe it's the definition of government and volunteer would be we would put out to LTPAC and behavioral health that this is what we recommend that you guys do in order to have real interoperability and interconnectivity between all care sectors and you can do it or you can't as somebody said, you know, there are people out there who don't use Medicare and they can do whatever they want to do.

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

This is Jodi Daniel, can I just jump in for one second? The one thing I just want to clarify is we're talking about the certification program separate not the Meaningful Use Program so we're talking about the requirements for the products or criteria for products or standards for products as opposed to the actions that a provider would have to take to use that system which is really kind of the behavior on the Meaningful Use side.

So, it would be about making sure that there are minimum functional criteria or standards criteria for the EHR products and I just want to make sure that people understand that distinction that this isn't about requirements on the providers and what they would need to do just the – it would be about the products that they may purchase and trying to have some level of standardization or consistency with those things that are important. So, I just want to make sure that people understand that distinction.

Joe Heyman, MD – Whittier IPA

Well, I understand it but I don't understand –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Let me jump in –

Joe Heyman, MD – Whittier IPA

Yeah, go ahead.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Let me jump in on Jodi's comment. So, if I get sort of very in the details for a moment we have today criteria that is organized by common core to both hospitals and EPs, eligible professionals, and we have some that is distinct to hospitals and eligible professionals. So, it seems like at the least there should be a review that says of the current criteria do they have embedded assumptions that assume that this is being used in hospital systems and if I wanted to go for modular certification I would have to do something that doesn't make sense in my care setting so I could check the box for that module because it was crafted bigger than is necessary and I'm specifically thinking around things about interoperability.

But it might extend beyond just for example CCD exchange. One of the things that is becoming a driver with ACOs, of their various flavors, is to have care protocols and that when a patient leaves one care setting and goes to the next care setting it continues in their care that for example, and I'll oversimplify, if they have a cardiac protocol that this community of providers has bought into that that protocol can in fact live in all of the systems that are used to provide the care.

And so whether or not we say there – so separate from whether it's required that your system be able to accept a protocol standard, assuming there was one out there, I think that might be an example of a capability that you could see wanting to have that would flow setting to setting and that it might make sense to say, if you're going to do a protocol-based care here is a standard, we're using it, and here is certification criteria so that all the vendors can attest, you know, can demonstrate that they can meet that standard and increase the likelihood that if a community takes on using some protocols they will actually be able to exchange them. And now I've drowned out everybody.

Joe Heyman, MD – Whittier IPA

Well, I guess I – this is Joe, I guess I'm just thinking to myself if that's what the community needs and they also need the interoperability just in general for a CDA which is about the most that any EMR can do when it's trying to connect with another EMR. Why not just allow competition to do that? Why does the government have to or anybody have to get involved in certifying that? That's what I guess I don't understand. I mean, I understand –

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

Well, maybe it's not –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, the argument would be that there are commercial certification bodies that do this in other areas and where standards need to be in place.

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

And maybe –

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, I wanted to insert a comment, because as I think about the discussion I think a lot of the value could be in this area of information exchange and my observation would be first Joe what you're doing right now with CDAs are hopefully a first step but there will be capabilities beyond that eventually for the systems to communicate a lot of information both ways and to do something I call consume the data into the EHRs so you get laboratory results and medication information from one EHR to another and it's consumed –

Joe Heyman, MD – Whittier IPA

Well, yes –

Paul Egerman – Businessman/Software Entrepreneur

Within that EHR and to me that would be –

Joe Heyman, MD – Whittier IPA

To do that –

Paul Egerman – Businessman/Software Entrepreneur

A lot of value to being able to have the test criteria for those interactions be a module and that that would be something that other segments as a healthcare industry could be using, because they would also be able then to participate in the communications and I think that in fact, if I remember John's comments correctly, it seemed like that might be helpful to him also.

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

This is John again, you know, one thing I think just came up, I think it was Paul, why would we want the government to certify that, maybe that's something that we could – maybe the word should be guidance to it because I had not thought about the government certifying, I mean, we – I was a trustee of CCHIT they volunteered to be a certification group that was – you know, and they do it with and without the government.

So, maybe we should be using the word guidance to other non-incentivize people and not set up that the government would certify it and have to pay money for it but people would say they can or cannot and maybe that's a better word than voluntary.

Joe Heyman, MD – Whittier IPA

Yeah, well, this is the Office of the National Coordinator so this is certainly the government.

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

True.

Joe Heyman, MD – Whittier IPA

But that's what –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, and I guess there are some things that I would like to see more broadly as standards. So I would like to see for example that the reporting that is done, the mandatory assessments that are done out of the non-incentivized, non-Meaningful Use or whatever we want to call them care settings that there is alignment with that and that the government has its act together and isn't creating different formats for different data sets and that in fact there is a common base that everybody can build on and that we start to get deeper adoption of standards because of that rather than sort of fragmenting both the vendor activities –

Joe Heyman, MD – Whittier IPA

But what I'm finding is that people are adopting –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And then requiring and are converted.

Joe Heyman, MD – Whittier IPA

People are adopting those standards voluntarily without certification, that's what I'm confused about. I mean, lab reporting and radiology reporting that was done before Meaningful Use. The CDA has been developed but even that was something that was developed before somebody was talking about Meaningful Use. And the other requirements of Meaningful Use haven't been all that wonderful for improving anybody's health. So, I'm just confused –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I think you're right, I think you're right, I know you're right Joe, you know, HL7 in its various flavors has been in place for a long time but in fact there was very little adoption and very little conformance to a consistent set of standards. You didn't have any kind of – anything approaching plug and play. We don't know how good we're going to be on even the Stage 2 criteria.

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

But it seems like we've made huge progress in terms of the ability of the systems to generate a standard document.

Joe Heyman, MD – Whittier IPA

Yes, that was because of the incentive program which forced EMR vendors to try to, although I don't think they've done it very successfully yet, to have that CDA be interoperable, but I don't think – without something forcing people to purchase EMRs that have certain criteria I think that just competition alone is making people, for example with long-term care, have products, this point/click something or other product, which I can't remember the exact name of in long-term care, but, I mean, they already have adopted some of these standards without anybody asking them to accept their customers obviously. But, I mean –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So –

Joe Heyman, MD – Whittier IPA

I'm certainly happy to talk about what potential standards there might be I'm just raising – I'm just not sure that we're not just creating busy work and a bureaucracy that isn't necessary. But, I'm more than happy to discuss what potential standards might be and, you know, how they could certify for them and everything else, I don't mean to be a total naysayer. I'm –

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

But I think that's what this group is supposed to be doing.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think you're right.

Joe Heyman, MD – Whittier IPA

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Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think that this is in fact raising good questions about why we would want to have a program, why would we want to expand certification beyond what it's currently doing and if we don't address these whatever else we come up with is going to sort of be raising that question, you know, perpetually.

So, I think these issues do need to be addressed and given our time constraint for today, which was basically to get the topic out there and then to have a follow-up early in November, so I'd like to get us to the next slide, slide eight, just to put these topics in front of you and to offer this as a framing for taking some next steps, and then maybe after we've gone those these five big buckets to then come back to this question of where is the value in what we're trying to – in extending the certification criteria at all and, you know, is it a question of labeling about voluntary because there may well be other government programs that are no more voluntary than Meaningful Use, but once you buy into them have mandated requirements and maybe there is in fact a role to be played in that setting.

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

And Larry, let me give another, this is John again, here is an example of what happened I know to some nursing homes up in the Northeast, the hospital came to them and said if you're going to be my preferred vendor or provider you must use my program and they said "well, we can't because it's MDS" and they said "I'm sorry, if you won't use our program" and they bullied them "then we will never send you anymore patients." And so maybe it's not – maybe it's just to say we are part of the whole situation so we don't get bullied, sorry, end of comment.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, we will continue this.

Joe Heyman, MD – Whittier IPA

Well, that hospital might still bully you even if there are criteria.

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

That's true.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's true. I think, I think – what, what do I think. I think we should look to wrap this up, we've had a lot of good discussion about pros and cons of even pursuing this, so we've got that as a beginning point. And I think we should dive into these five things in our next call. And so unless there is any strong objections I think we should open this up for public comment.

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

Larry, this is Marc, just real quickly, so a lot of – I thought there was a lot of good comments and ONC initiated the desire for this to be looked at. It would be nice if they could kind of consolidate what was just said and maybe help create some responses prior to the next meeting to those questions.

Joe Heyman, MD – Whittier IPA

I think that's a great idea.

Elizabeth Palena-Hall – Office of the National Coordinator

This is Liz, we can certainly do that.

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

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Thanks.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

This is Michelle, so we'll probably do that and then follow up with the Chairs to make sure that we're all on the same page.

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

Perfect.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

With that do you all want to open the lines for public comment?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes, please.

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Operator can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have one comment, Jennie go ahead.

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

Hi, this is Jennie Harvell and I wanted to thank the Office of the National Coordinator for advancing this initiative and thank the Sub-Workgroup for the conversation, it was very interesting. I just wanted to add a few comments, while private sector certification for long-term post acute care providers has been available for several years adoption of that technology by long-term post acute care providers has been very sparse. I don't have the data at my fingertips regarding behavioral health provider's adoption of CCHIT certified technology.

In addition, there have been some difference between the CCHIT certified products and the functionality required by ONC in the EHR Incentive Program. And finally, I think, again I applaud ONC in advancing this effort because I think interoperable exchange between long-term post acute care providers and behavioral health providers, and those providers who are eligible for the incentive program hopefully would be enhanced through the identification of criteria to support interoperable exchange, but in addition to that I think, I hope this group would undertake an effort to look at what additional Health IT functionality and criteria might be needed for these providers in a way to support care giving and the quality of care that they deliver to their patients. Thank you.

Ashley Griffin – Management Assistant – Altarum Institute

We have no further public comments.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you and thank you everyone and Marc and Larry we'll be in touch soon to follow up from today's call.

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

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay and a reminder we have our next call on November 4th.

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

Have a great weekend.

Public Comment Received During the Meeting

1. Adding new criteria to a 'voluntary certification' beyond the existing 2014 Edition criteria would slow the time frame that vendors would sign up for this 'voluntary certification'. If the goal is interoperability of information to these sites, use the current CCDA standard for Summary of Care. There might be a few additional sections appropriate for the LTPAC or BH patient information.