

**HIT Policy Committee
Certification & Adoption Workgroup
Transcript
January 17, 2014**

Presentation

Operator

All lines are bridged with the public.

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

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

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

I'm here.

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

Hi Marc. 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

Hi Larry. Mike Lardieri? Joan Ash?

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

I'm 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. Carl Dvorak? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Hi again Paul. Joseph 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. George Hripcsak? Stan Huff? Liz Johnson? Donald Rucker? Paul Tang? Micky Tripathi? Maureen Boyle?

Maureen Boyle, PhD – Substance Abuse & Mental Health Services Administration

Here.

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

Jennie Harvell? And are there any ONC staff members on the line?

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

Hi Michelle, Elise Sweeney-Anthony here.

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

Liz Palena-Hall here.

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

Hi Liz.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Stella Mandl here.

Rhonda Poirier, DrPH – Senior Advisor for Policy & Progress – Office of the National Coordinator for Health Information Technology

And Rhonda Poirier here.

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

Hi Rhonda. And with that I will turn it back to you Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so we'll start with a quick review of the agenda so let's go to the next slide. So, we have a couple of slides that are reminders of what our charge is and then we'll hear from – I think I've got the order right here, then we'll hear from Michelle Dougherty who is going to speak from the perspective of the LTPAC Health IT Collaborative and some roadmaps they've developed over the years and talk about sort of a combination of provider and vendor view. We're hoping that that's a pretty short discussion and presentation about 5 minutes for Michelle to present and 5 minutes for us to discuss.

And then we're going to dive into the meat of what we've got as, you know, what we learned from the hearings and where we think that should go. As you recall from last time those individual items are all organized by some broad headings that have been of value to Meaningful Use certification, they sort of follow the framework that's being used and so we're looking to sort of relatively quickly go through the bullet items with a sense of is this particular item important to LTPAC, is there some important aspect of the area that we're including or excluding and the reason for it and try to move through these.

It's a little bit of clogging through the mud here but I think we need to do it and I'm going to try and be unusual and keep the pace pretty crisp as we go through them. We've got this call and we've reshuffled a little bit when behavioral health starts so that we have the call next week to finish, but we still have a lot to do this week to be able to finish next week with LTPAC. So, I think that's about it for highlights so far. So, let's go to the next slide.

So, as you can see we've claimed 1/21 to continue this work and get it finished. Hopefully, we'll be at a place where we actually can talk about draft recommendations next week and then we'll pick up on behavioral health. Next slide. Okay, this should be yours Michelle, take it away.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

Great, thanks Larry and hello everyone, you can turn to the – there we go on the next slide. I'm going to take the next 5 minutes to highlight information from roadmaps, a result by a group called the LTPAC Health IT Collaborative. Next slide.

The collaborative is a group of stakeholders from key trade associations as well as professional and vendor association representatives from provider organizations, researchers and government staff that came together starting in 2005 to both strategize as well as advance Health IT initiatives for the LTPAC sector. The associations on the collaborative represent the majority of providers in LTPAC settings particularly the senior living communities, the nursing homes and home health. Next slide.

The collaborative uses a biennial publishing of a roadmap to communicate their consensus agreement on strategies and priorities which then the group advances out into the broader community the roadmap through an annual summit, through their website, by the members of the collaborative through their association, you know, activities, standards development work through, you know, joint comment and response letters, face-to-face meetings, etcetera, through just a number of different methods. Next slide.

So, to get into the heart or the meat of what the roadmap priorities have been over the years I put together this slide to identify what were eight key themes, you know, across the past nine years, they included leveraging Health IT to support care delivery models and in particular the new care delivery and business models that have emerged with healthcare reform.

To increase adoption and use of EHRs and Health IT by supporting the development of tools and resources targeted to the providers, by advocating for policies and programs to be leveraged and by showcasing to the larger community innovations that improve care outcomes, improve efficiency, improve cost-effectiveness.

Another theme was, and emerged since the very first roadmap, the collaborative advocated for the adoption and use of Health IT standards and certification programs for LTPAC, EHR and ePrescribing solutions. We're going to look at this a little more in depth on the next slide so I'm going to move on.

The next theme, no I'm sorry, back, if you can go back, there we go, the next theme, in addition to standards and certification priorities the roadmaps advocated for health information exchange and interoperability recognizing the importance and the frequency of information exchange that occurs between LTPAC providers and external clinicians and organizations to support the transition of care process during shared care including processes like medication prescribing and management, assessment, care planning, status change communication, as well as exchange that occurs to support administrative processes like surveys, mandatory quality and public health reporting and payment.

The roadmap also called for specific initiatives to support transitions of care and care coordination, early on called for the development of a standardized transfer summary and record of care, ePrescribing and advancing patient centered care planning that crossed all caregivers and providers.

So, I mentioned ePrescribing has come up a number of times but ePrescribing and medication management has been an important theme across the roadmap to improve the safety and collaboration with others in the healthcare sector.

Quality measurement and improvement was also identified as a key priority across the roadmap particularly to engage LTPAC and the patients they serve to foster a more person-centered, harmonized quality initiative throughout the spectrum of care.

And finally the roadmaps advocated for leveraging technology to support the consumer, their family and caregivers to be engaged not only in their healthcare but also to support their wellness, their independence and control. Next slide.

This slide provides additional focus on key strategies around the topic you've been discussing as a roadmap, I'm sorry as a Workgroup, that reflects some initiatives from the roadmaps over the years related to certification, HIE and interoperability. The very first roadmap called out that importance of certification of EHRs and ePrescribing solutions for LTPAC to reduce risk. It also called to action the community to get engaged in standards development activities. Prior to that there was little engagement of LTPAC experts in the standard's community.

The second roadmap continued on that foundational work to advance certification programs for LTPAC and then urged the communities to begin demonstrating the use of some of these emerging standards. By 2010 CCHIT had developed an LTPAC certification program, as you know that was pre-HITECH, so the roadmap began to advocate for advancing awareness and promoting adoption of certification as well as advocating for LTPAC to be included in the emerging health information exchange organizations and to prioritize transitions of care as well as ePrescribing.

And finally the roadmap, the final roadmap, identified interoperability standards and certification as an important strategy to achieve enhanced care coordination between LTPAC and their multiple external clinical partners. Next slide.

So, in closing I want to leave with a point-of-view of the collaborative since the issue of incentives has been discussed by the group. I think the 2008 roadmap kind of did a nice job of summarizing the discussion or the perception of the collaborative recognizing that incentives and other policies would help accelerate adoption and the collaborative would seek inclusion where it could leverage these policies, however, the collaborative also advocated that the sector not sit passively and wait for regulatory and reimbursement changes and to be proactive in developing their own strategies that leveraged Health IT to serve the seniors and their families.

You know, so just to wrap up in summary the development of voluntary certification process that are aligned to the key clinical and business strategies identified in the roadmaps are very important particularly where they advance interoperability and exchange with external organizations and they would be of value to LTPAC. Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, thank you Michelle. So, we've got a couple of minutes for discussion. Are there any questions that members of the Workgroup have for Michelle?

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

This is Joan and I have one, which is do you see any downsides to the concepts our Workgroup has been discussing for voluntary certification?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

An issue that has come up, certainly in the collaborative, is advancing a certification program that gets into unfunded mandate areas that doesn't align with what is of key clinical and business value to the sector and of course what's important is the voluntary component as well. But where it can really assist the sector with key clinical and business processes and improve outcomes or improve efficiency that would be very valuable to the sector.

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

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Any other comments or questions for Michelle?

Joe Heyman, MD – Whittier IPA

This is Joe, I guess what I would say is I would have excruciating sensitivity to Michelle's statement about improving efficiency when you're doing this.

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

Hi Joe, this is Michelle; it's really hard to hear you I don't know if there is anything that you can do on your end?

Joe Heyman, MD – Whittier IPA

Can you hear me now?

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

Much better, thank you.

Joe Heyman, MD – Whittier IPA

Okay, I'm sorry, I would say that listening to you Michelle I would caution for excruciating sensitivity to your suggestion that these processes should increase efficiency, because my experience so far is exactly the opposite.

So, I think that when we're thinking about moving ahead and trying to align what your needs are with certification it's really important to make certain that we're not slowing down things and interfering with innovation, etcetera.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

And that's –

Joe Heyman, MD – Whittier IPA

And adding extra clicks and that kind of stuff.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

Yes, that's a great point. I think what's important to know is it's about the care delivery processes in the LTPAC sector. It's particularly heavy with exchange between clinical partners and other organizations and technology hasn't advanced to where the communication process is efficient.

So, there are often redundant paperwork processes that are occurring both for the PTPAC provider, the multiple communication with physicians, the need to maintain duplicate, you know, documentation and recording processes.

So, there is a lot of inefficiencies with these paper-burden processes and there is no technology or clicks generally in place yet that allows those systems to talk to one another.

Joe Heyman, MD – Whittier IPA

Well are there innovative strategies on the part of vendors to handle those issues?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

What's interesting about – there is certainly innovation by the vendors in the sector. When you look at these communication practices, processes between LTPAC and physician practice EHRs or hospital EHRs it requires both parties to prioritize this communication and to come to some agreement and so the value of what this voluntary certification process can bring is honing in on key processes and key standards that will facilitate that communication and as well as the types of use cases that will get information moving that fit for purpose the communication that occurs.

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

This is John Derr and I worked a lot with the vendors as well as being a provider and the vendors do have it built in, not many of our actual facilities have the newer upgrades of the vendors EMRs, but they are building them.

And just FYI about 2 years ago at one of the big LTPAC meetings CMS announced that they were going to cut the Medicare reimbursements and one of the reasons they were going to cut it was because of increased productivity and efficiencies of EMRs.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It sounds like a Catch-22. So, any other comments before we move onto the next topic? Okay, well Michelle –

Carl D. Dvorak – Chief Operating Officer – Epic Systems

–

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Go ahead?

Carl D. Dvorak – Chief Operating Officer – Epic Systems

I had put the phone on mute and forgot to put it off mute. Is it possible maybe to get representatives from the leading one or two, or three LTPAC vendors directly on the phone and help make sure we understand if they understand what certification really means?

Because I see us vacillate a little bit back and forth between wouldn't it be nice if there was communication, but I think that might actually take care of itself once all the hospitals and all the physician's offices have a common communication protocol and HIE is mature. I think that might naturally become something LTPAC organizations could then draft on. I mean, it's hard to do that when that isn't in place in the first place. But, I wonder if –

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

This is John Derr, there is a group called NASL which is part of the collaborative and they have all the IT people that would do SNFs and assisted living and then there is HCTAA which is also part of the collaborative and that's the home care and hospice IT and technology people and on the phone right now, because they listen in on all these plus they are members of the S&I Framework and yesterday Larry and I to a certain extent at the NASL IT Committee which I formed in '98 because HIMSS doesn't support LTPAC, we keep them really involved in this whole thing.

So, we can put them on as members but they're listening for sure and as stated yesterday in a meeting by the Chair of the IT Committee they said that they support this thing wholly.

So, you know, a lot of them have worked it and they have ONC certification and CCHIT certification. So, they've been listening all along because they support this initiative and they want to be involved.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul Egerman, I hear that comment, but that was different than the information I heard at the hearing where all of the vendors showed only limited support for ONC involvement. They only wanted – all the vendors wanted one of two things which was either a restriction to standards relating to, I guess information exchange that was one thing, and one vendor said they didn't want ONC to do it at all. So, I just don't know how to reconcile what you just said with what I heard in the hearing.

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

Well, I think the one that said they didn't want to do it at all was not one of the major IT vendors for LTPAC and if you want them to be part of the Workgroup I'm sure they would be very happy to do so, but I don't agree with that conclusion and I think if you talk to them directly they would all support it.

Because again, we're all afraid of an unfunded mandate that comes out of CMS because eventually there is going to be interconnectivity and interoperability.

And if we don't have some commonality across lines we will not have the trust of the hospitals and the physicians, and trust, as John Halamka always says is very, very important to us that when information is traded there is a trust value and that's why we did the –

Paul Egerman – Businessman/Software Entrepreneur

I thought –

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

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul again, I'm still a little confused or concerned. So, you're suggesting that we should ignore what was said at the hearing from the vendors?

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

I'm not saying – you tagged on one because I know John Damgard didn't say that and he is one of the major vendors. So, I think you have to take all of that as who is saying it and what groups and then if you want to know just ask NASL and HCTAA who represents all of them whether they support some type of volunteer standards or not and that way if that would satisfy you I'm sure that could be a new game.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation
Right –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, cut to the chase, so we'll check in with the association guys and see if we can get someone to join us on one of the next calls.

Joe Heyman, MD – Whittier IPA

You're talking about the vendor association?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

Joe Heyman, MD – Whittier IPA

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, any other comments before we move on?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

Larry could I just make one quick response and then we can wrap up. I think it's important to understand that the processes, standard and certification processes, for communication between hospitals and physicians haven't always been a fit for purpose when you look at the LTPAC sector. So, some modifications and some tweaking has to occur ePrescribing is maybe a good example of that where it's not a perfect fit, it's a great start and to get all parties involved centralizing around a set of standards would be very important.

Joe Heyman, MD – Whittier IPA

This is Joe, I guess the only thing I would add is that we're starting a health information exchange in our community in the Northeastern part of Massachusetts and one of our first sign-ons is the Home Health VNA and they use something called HealthyWyse, I don't know, HealthWyse, W-Y-S-E is their EMR company and we're planning on having all of this stuff work whether it's certified or not.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

I think once you get critical mass on certification the likelihood that others would follow that without additional regulatory overhead is extraordinarily high. I doubt you could survive in the market if you weren't able to adapt to that.

So, I just – I know John you've got a lot of passion for it and yet I've listened to John Halamka through time and I think if you ask John in a private moment, maybe we should, are you a fan of certification at this moment I'm not sure what answer you get.

But I do think we should try to let natural forces succeed where they really could have succeeded and I do worry about bringing additional regulatory burden to a fragile market already.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I think we should take that under advisement as we look towards what we actually wind up recommending. My sense is that in many cases we're going to wind up saying there are existing certification criteria, they are in place, they define the standards and we think it's important that people meet those standards and I think the extent to which we have vendor experience on board that says there may be particular issues meeting this criteria because of either how the criteria is framed or the standard is, you know, referenced that might be useful to include as well.

So, you know, I don't know that we're specifically looking to create new things here but I think that the intention was to be able to say what parts of the current certification program are applicable in this space and clarify for vendors and providers these are the things – if you're going to focus on things these are the things to focus on. You know, to your point Carl that's where critical mass is happening in the acute care community because that's what is funded.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul, what you just said Larry is very helpful but I don't see that is like written down as like one of our basic or fundamental principles which is to not create anything new to simply, you know, reuse the existing certification criteria. Shouldn't we just be making sure there is consensus on that and that, you know, we somehow write that down.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I think that we'll actually get to that in the next slide or two.

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

Larry, this is Jennie.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah?

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

And I'm sorry for chiming in I had a bit of a phone problem, chiming in so late, but I just wanted to comment following up on the conversation just a couple of minutes ago that both NASL, the National Association to Support Long-Term Care and HCTAA have provided comments in writing and/or verbally to this Workgroup about their support for voluntary certification criteria for long-term post-acute care. And so I think we can go back and retrieve the submissions by those groups if the Workgroup wanted to read that.

Paul Egerman – Businessman/Software Entrepreneur

That would be helpful.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Thanks.

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

And this is Joan and I'd like to make a comment about the vendor's side as well and that is that I keep hearing this groundswell of support from the organizations and the individuals who would be customers and it seems like the vendors it would be in their best interest to respond to this groundswell of customer encouragement to meet this market. So, it seems to me there would be a business case on the part of the vendors to provide what the customers want.

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

I guess that's true and I think that's generally reflected in the long-term post-acute care vendor's support for this Workgroup's activity.

Joe Heyman, MD – Whittier IPA

This is Joe; I would say that the vendors should be giving the customers what they want in their products that's something different from asking for certification.

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

This is John Derr again, I'm sorry, but, you know, I've sat through and I know every vendor, I've sat through every demonstration because I'm agnostic in the vendors and I think this group if they want to really know what the vendors can provide then we ought to set up some demonstrations or something like that.

But, let me tell you their EMRs are very robust and they're different from acute care vendors because they have to adhere to all the rules, but they are moving far ahead in decision making and analytics and remember they've been doing longitudinal care for years now and if this committee, if this Workgroup needs to be demoed on all of the great things that they have – they just don't have the facilities just don't have all the money to buy the upgrades and that's an issue, because we were not part of the incentive plan.

Joe Heyman, MD – Whittier IPA

Well, the price of those upgrades will go up if there is a requirement for certification.

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

I don't know that for sure. I don't think they went up when they did their CCHIT certification.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Having –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay guys, you know, we're not going to resolve this today –

Joe Heyman, MD – Whittier IPA

All right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Or even in 6 subsequent calls. So –

Joe Heyman, MD – Whittier IPA

But I do think we might –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I –

Joe Heyman, MD – Whittier IPA

Need some vendors on this call. I mean –

Carl D. Dvorak – Chief Operating Officer – Epic Systems

I think having the vendors personally on the call will matter and having done CCHIT and having done ONC certification it goes up by an order of magnitude it's not subtle.

So, I do think – I would like to personally hear from the actual vendors themselves because there is no reason they couldn't speak for themselves on the matter and if they'd like to so be it, it's okay.

I don't have any objection I just want to be careful that we don't accidentally make a decision based on what we thought they wanted to do only to find out later they either understand it or didn't really want to do it. I think that's our responsibility ultimately.

Joe Heyman, MD – Whittier IPA

But there is certainly no question, no question that the cost of software for us, for us docs, has gone up extraordinarily since the Meaningful Use Program came and most of the innovation is just around Meaningful Use it's not around all the other things that used to be important to us.

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

This is Michelle; I'm just going to have to ask that we move the conversation along now.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

I apologize – I have drop off early today unfortunately so I do apologize but I'll have to drop off. Bye.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay. Okay, guys let's get back to the slides for a minute. So, I've got us on, I think its slide 10, let's move onto the next slide. Thank you and okay.

So, we've got a two-part charge which we've been clearly in the middle of about capabilities that would improve interoperability across a greater number of care settings and specific recommendations related to providers that are not getting funding from HITECH and I think to all the discussion we've had issues of how HITECH has shaped the marketplace and really important to understand because it's had a lot of consequences to price and, as you guys have been pointing out where the vendors have focused their efforts.

Paul Egerman – Businessman/Software Entrepreneur

And –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, let's move onto the next slide?

Paul Egerman – Businessman/Software Entrepreneur

And so Larry a question I have on this slide, it says recommendation shall take into account previously adopted certification criteria.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

Paul Egerman – Businessman/Software Entrepreneur

That's not quite the same as what you said before. In other words, are we limiting ourselves and only doing that or are we just going to think about it but we have greater flexibility and we can create whatever criteria we want.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I think we could create whatever we wanted that's not my recommendation. My recommendation is that we're very – where we identify areas that aren't covered in current criteria that they get very focused consideration, that in general and broadly we should be using existing criteria.

Paul Egerman – Businessman/Software Entrepreneur

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Next slide, please. So, we're deep in the middle of step two, we've been through our general discussion of certification process and how things have been going with Meaningful Use and a framework of why ONC might go down this road of additional certification including looking at cost and unintended consequences.

We're now in the middle of LTPAC hopefully hitting the – turning the corner on LTPAC and starting the end of next week we'll be picking up discussions on behavioral health. And then finally, looking towards March set of recommendations to the Policy Committee. Thank you. Next slide.

Okay, guiding principles, so maybe this needs to be even clearer about build on and align with existing criterion and standards in the Health IT sector. But that the intention here is not to build a new certification program but to build on the existing program, to build on existing criteria and to look at the areas where the existing criteria seem to speak directly to LTPAC, and where there are some industry specific gaps and we'll see others I believe when we do behavioral health and I think we have a very small set of things to say. These are areas that are not covered in the current criteria that are important to the sector but in general the things we're talking about I think are covered.

And again, a focus on privacy, security, transitions of care, interoperability and then finally that setting specific pieces are not in this program today. So, that's the one exception Paul to what you're asking me to –

Paul Egerman – Businessman/Software Entrepreneur

Yeah and I'm confused could you just explain that for me, the setting specific, what you're saying there?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, so we'll get to that in the details, but generally there are things like there are regulated assessments in each of the care settings, so SNFs have to do something called MDS, Minimum Data Set, and it's a periodic collection of information about a patient, it's called an assessment, but it is not the kind of hands on clinical assessment that most providers think of when you use the word assessment. So, it's very specific to the mandated assessments that we're talking about here.

The survey is the regulatory survey process which requires that surveyors have read access to electronic records and so is there a way to facilitate that access? And finally, there are issues around potential certification of the healthcare setting and the –

Paul Egerman – Businessman/Software Entrepreneur

What you're calling certification in like hospitals is called accreditation, is that what it is –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

Paul Egerman – Businessman/Software Entrepreneur

That you talk about here.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

That's helpful; I did not understand this fourth bullet when I first read it. I would tell you I'm fine with the first three, I'm not sure what I think about the fourth one, but mainly because I don't quite understand what you're talking about there but –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, well, we'll get to them.

Paul Egerman – Businessman/Software Entrepreneur

The first three make a lot of sense to me but the fourth one I think you've got to be careful about.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, okay and I have to say that as we look at some of the subsequent slides I actually think there is another bullet of where we're using other criteria that are probably broader than interoperability. So, we'll have to look at that as we go through those slides.

And to your point, to what extent are we expanding, extending current criteria or are we just acknowledging alignment with current criteria.

Joe Heyman, MD – Whittier IPA

This is Joe –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, let's move onto the next slide.

Joe Heyman, MD – Whittier IPA

This is Joe, I just – I'm a little concerned if a guiding principle, the fourth bullet, is something that we're not clear about. If you're going to call these guiding principles we ought to be very specific about what that fourth bullet means.

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

Hi, this is Elise from ONC, I might suggest that maybe we walk through the slides and then maybe revisit that question once you – so that would give an opportunity for slide four to be better understood based upon what's in the latter part of the deck. Larry would that work?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think that makes sense because that will get us to the specifics and I also think that, as I started to say, I think the guiding principle is to build on and align with existing criterion standards that's the guiding principle, we feel like it's going to apply without I think a whole lot of argument in these top three.

I think that you'll see, as we go through the slides, that there are a couple of other things that have been touched on that builds on existing criteria that are not highlighted here and probably should be and finally they're setting specific issues which are in detail on the subsequent slides and so that area I think will get clarified when we get to it and we will revisit this before we're done I have no problems with that, in fact I think that's important.

Paul Egerman – Businessman/Software Entrepreneur

And I know we want to move on I just want to make an observation.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Go?

Paul Egerman – Businessman/Software Entrepreneur

If we did nothing more but did standards around transitions of care we would probably do – we will have accomplished a lot.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's true. So, that's probably a great thing to remember as we go through this. Let's go onto the next slide.

So, we've been through this painfully I think, it was the public RFI, we had a hearing with testimony and letters and we've had some additional presentations. I probably should point out that there was another health provider letter submitted, Samantha Burch of the Federation of American Hospitals couldn't make the hearing, but we were going to have her on one of the subsequent calls but decided because of time that we wouldn't have her present live but her testimony was e-mailed out to all you guys and is on the public viewing of this webcast as an additional item. So, broad input from a lot of different sources, providers, vendors, others in the space.

We've had some analysis from ONC and ASPE of what criteria vendors have chosen to certify against and again I think that is going to speak to how the existing program is working, people can use modular certification and have used modular certification and there seems to be some value in the marketplace for that.

And finally, to the point about transitions of care, there is a – I guess it was balloted this fall and is still in ballot resolution with HL7, additions to transitions of care and care plan standards. So, things are in the works. Next slide, please.

Are they on the right screen? I'm not on the right screen, sorry. We had some discussion last week about do we mean interoperability or did mean exchange? So, I've had some discussions with ONC about this and they were pretty clear that they mean interoperability and so I think we need to understand that and I think we actually mean interoperability given what we've been talking about.

The evolution I'm seeing in the marketplace, which was maybe my personal sensitivity around how interoperable are things really is certainly for the Meaningful Use 1 edition systems that CDA documents are being exchanged as documents and there is very limited uptake of the code sets that they contain not that it's zero but it's still pretty limited. So, I believe that there is a glidepath here for use to improve based on the standard documents. But our charge is really to look at interoperability and not just moving the documents.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and this is Paul, I understand this definition, so I understand that that's what the charge is interoperability is definitely broader than information exchange. Information exchange is when you exchange information between separate entities, you know, between an extended care facility and a separate pharmacy.

Interoperability is exchanging information, includes that but also includes exchange information internally within components so it could include, you know, how information goes from the, you know, the PACS, radiology PACS reading station into a radiology information system or it could include how information goes from some laboratory test equipment into the laboratory information system and that's fine if we want to be that broad. But it's probably broader I think than we need to be but that's my observation.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay and I think that the key thing here Paul is that they are looking at interoperability as exchange and use. So, I don't think –

Paul Egerman – Businessman/Software Entrepreneur

Well, exchange and use is still information exchange. I mean, it's still information exchange.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right, right, I don't think the –

Paul Egerman – Businessman/Software Entrepreneur

The issue here is its components which is right on the definition, but this is sort of an arcane subject why don't we continue on I think.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, let's go onto the next slide. Okay, so, this slide and the next slide are breakouts of individual items in the current certification criteria, almost all of them, so this again is talking back to that principle slide, where there is going to be subsequent slides that are the details and some of these break out what might be part of interoperability and others look more towards – let's look at the next slide.

Others like, you know, problem list, medication list, allergy list start to span both spaces, right, because in order to exchange a problem list you need to have a problem list and if we're looking at medications and we heard a lot about medications during the hearing as being an important process you need to have an internal process that uses the medication information and integrates it into the care process and not just have it for exchange.

So, I think these are some of the things that are in that gap, if you will, between the top three we've identified about privacy/security, transitions of care and interoperability and then setting specific things. These are general things that –

Joe Heyman, MD – Whittier IPA

What's eMAR?

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, just an observation, Stage 3 hasn't been approved yet, I think it showed it with an asterisk so maybe that's what that asterisk meant, but it's a fairly long way from approval. So we don't quite know what's in Stage 3.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's correct.

Joe Heyman, MD – Whittier IPA

What's eMAR?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And I think the reason that there were a couple of Stage 3's here with the asterisk is that there have been some recommendations from the Meaningful Use Workgroup but they're clearly not – they don't yet exist in certification criteria or –

Paul Egerman – Businessman/Software Entrepreneur

Well, they – I mean, some have been approved by the Policy Committee because the Workgroup is just a Workgroup, so some have been approved by the Policy Committee.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

But it still has to go through the entire regulatory process to see what CMS is going to include, so it's –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

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

Hi, this is –

Paul Egerman – Businessman/Software Entrepreneur

– pardon me?

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

Hi, this is Elise from ONC, that's correct the asterisk indicates what's under consideration by the Meaningful Use Workgroup it is not from ONC or CMS specific, it's referencing the Meaningful Use Workgroup and what's under consideration at that time.

Joe Heyman, MD – Whittier IPA

And could somebody tell me what E-M-A-R is?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

This is Michelle, electronic medication administration record.

Joe Heyman, MD – Whittier IPA

I see, okay.

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

Which they do by paper now, this is John Derr.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, mixed depending on the site they may have all kinds of ways they do medication administration records. Okay, let's go onto the next slide. So, this lays out how we're looking to proceed here.

So, we're going to have a slide that identifies the three column slides that you might have seen in last week's slide deck are brought forward here. So, a little bit about the history, what we heard at the hearings, a discussion of the proposal, what's in the box on the right and then looking to agree or not that the items are in fact a key Health IT capability that would be of value in the setting based on what we've heard so far. So, that's the approach for what's about to follow. So, next slide. Yeah?

Paul Egerman – Businessman/Software Entrepreneur

So, the criteria is a key Health IT capability?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

In other words it has nothing to do with necessarily helping with the rest of the Meaningful Use Program or other interoperability, it just says we think it's a key healthcare IT capability that's important to do?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, that's a good question.

Paul Egerman – Businessman/Software Entrepreneur

That seems pretty broad.

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

Hi, Larry, this is Elise, just to give some clarity on that, what's in quotations "key Health IT capability needed" derives from the charge that the HCPCS provided to the Workgroup and that's where that is pulled from.

And in terms of what is considered key I think that's up to the Workgroup what's been identified so far, interoperability has come up a number of times in terms of the presentations and the hearing so I think that goes to your question regarding interoperability.

But we pulled that from the charge to make sure that we were consistent with what the Workgroup has been asked to accomplish.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so I think cycling back to the earlier discussions we're going to need to go back to those original principle slides when we're done to identify what we did and why we did it. Let's go onto the next slide. So, I'm going to jump to the chase here and say that there is a separate Workgroup looking at quality measures and we should let them address quality measures. The proposal here is that –

Joe Heyman, MD – Whittier IPA

Well, this is Joe.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah?

Joe Heyman, MD – Whittier IPA

I think what we should insist on though is that whatever quality measures they come up with that they do not interfere with workflow, that they have to figure out a way to do it without interfering with the workflow otherwise we're not learning anything from past history.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, I have – Joe's comment is a good one. I would have an alternate comment which is I don't think quality measures should be included at all in this process, especially since it's going to be a Stage 1, it's voluntary, I think, you know, I made the comment if we could do transitions of care that alone would be huge and we ought to focus on things like that.

It seems like everybody wants to create a quality measure, it's the most amazing thing in the world, the number of quality measures that exist right now and it's a lot of work to produce that, it's a lot of workflow, as Joe pointed out, and, you know –

Joe Heyman, MD – Whittier IPA

And the people who – the people doing the measuring are not the people getting the benefit.

Paul Egerman – Businessman/Software Entrepreneur

Well, it's sort of like, I mean, I'm on a – for Boston Medical Center I'm on the Patient Safety and Quality Committee and, you know, we have over 400 measures that we're supposed to look at that we're required to look at, but we don't pay attention to all 400 it's overwhelming, we couldn't possibly do that and so to add new quality measures I view as problematic.

I think if we want to launch this program and do a good job with it and realize that whatever we do in the first stage isn't final. I mean, you can do subsequent certifications. I think we should be introducing something new rather than a Workgroup defining new measures.

Joe Heyman, MD – Whittier IPA

Also, this is Joe, I made this point last time but I'll just make it again, I think that asking vendors to do quality measurement through their software is stifling innovation because there is plenty of opportunity to create applications that can do quality measurement outside of the software by just using the database itself and I just think this is wrong, to make a rule that vendor software for electronic recording keeping should have to do quality measurement.

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

So, this is Jennie and at least when I read this proposed area for certification and the words that are in that box what it says is that the Workgroup would be requesting the Policy Committee Quality Measures Workgroup to discuss clinical quality measures further and provide recommendations back to this Workgroup on potential clinical quality measurement opportunities for long-term post-acute care.

You know I think it's kind of prejudging at this point what that Quality Measurement Workgroup might suggest back to this Certification and Adoption Workgroup.

You know we heard testimony from Crystal Kallem about the complexities of quality measurement in the long-term post-acute care space and she went through a whole series of complications in that area that I think really need to be teased out and considered. We also heard some issues with CMS.

So, you know, I think I personally like this recommendation of referring to the Quality Measurement Workgroup because I think there are, completely beyond certification at this point, quality measurement issues in long-term post-acute care that need to be reflected upon and I think it will be interesting, it could be very interesting and instructive for this Quality Measurement Workgroup to think about that and perhaps identify a way forward in addressing some of those issues.

Joe Heyman, MD – Whittier IPA

But when doing it –

Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology – Health & Human Services

Jennie Harvell, I'm sorry this is Kelly Cronin from ONC I would just add some context from sort of a policy perspective about where CMS and HHS is going with the implementation of value-based purchasing and even some work that's ongoing with the Accountable Care Workgroup and the Subgroup on measures.

There is a lot of input and deliberation now on thinking about sort of a new, you know, set or going into a new era of measurement where it would be longitudinal across settings of care and over time and we need to think about the data and structure for that but clearly building on existing standards, which the QRDA and other standards support.

So, I don't think we're talking about getting necessarily a lot of new standards or functionality that's, you know, very different from what already exists in the Health IT Certification Program and the Cypress tools and, you know, what the CMS portfolio is already supporting.

But I think we're looking to support this growing need to manage across the care continuum keep people accountable for managing across the care continuum and knowing that the measurement infrastructure is going to have to evolve in that direction, I think we're looking for input on this, you know, sort of, you know, explore this possibility.

It's also, you know, I think now public that the innovation center is going to be pursuing value-based purchasing on long-term care for SNFs and potentially home health. So, you know, there's a lot of movement towards accountable care and a variety of mechanisms and we need to be thoughtful in planning for that.

Joe Heyman, MD – Whittier IPA

But this is –

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

This is John Derr, there is also an NQF, M-A-P, MAP Subgroup on long-term post-acute care harmonizing the quality measures across a spectrum of care and making them more person centric.

Joe Heyman, MD – Whittier IPA

But this is in the setting of certification.

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

So following up, I would, again say, I think it's a good recommendation to make a request that the Quality Measures Workgroup think about this area and think thoughtfully how to move it forward.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, I guess I just disagree, I mean, I think – don't get me wrong, I think it's a wonderful thing that people are very interested in this, but I'm still trying to understand what is our focus and is the focus of our certification effort to change how LTPAC, how the LTPAC environment is managed, is it to improve the quality of care or is it to focus on information exchange and exchange with, you know, making these systems be able to talk to each other and I'm saying in the first stage let's just get these systems to talk together that would talk to each other, that would be a huge accomplishment.

Going down this path of the quality measures it will take a very long time and it will add a huge amount of complexity, and it's being added to an environment which is already pretty heavily regulated on all kinds of things that they have to report on and it includes all kinds of quality stuff.

Joe Heyman, MD – Whittier IPA

And this is Joe, I just want to make it perfectly clear I'm not against quality measurement I think it's very, very important I think it should be done and I think if long-term care isn't doing measurement on what they're accomplishing then that's a definite loss.

What I'm concerned about is putting it in an environment of certification that is my concern and once you go to another Workgroup and tell them to go produce something and then bring it back to us it makes it twice as hard to try to not include it in certification.

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

–

Joe Heyman, MD – Whittier IPA

So, I think they should be listening – I think should be – I think that Workgroup should be thinking about long-term care no question, but I'm not sure it should be in the environment of certification.

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

So, this is Michelle, I think we need to move on from this one, but I will say, the Quality Measure Workgroup just presented their recommendations for Stage 3 to the Policy Committee earlier this week and as Kelly mentioned some of their thinking integrates well with I believe what could be appropriate for LTPAC's today.

So, perhaps I could suggest that we have a combined meeting or at least have the Chairs from the Quality Measures Workgroup share some of their recommendations, how those might be relevant to the LTPAC setting and then we can kind of think through what would be appropriate for certification and perhaps we could do it together with both behavioral health and LTPAC. So, I suggest that we move on from this –

Joe Heyman, MD – Whittier IPA

Well, yeah, I'm understanding that Michelle, but just let me say one other thing. Larry, I think there needs to be a way when there is some disagreement about something to not just skip it and move on but actually to finally come to a conclusion and if the conclusion is to just skip it and then have it appear on the slide when you go to the Policy Committee I don't think that's sufficient.

Paul Egerman – Businessman/Software Entrepreneur

Well or alternatively Joe I think it would be fine to simply when you report is to report that there was disagreement, I think that's a valuable piece of information.

Joe Heyman, MD – Whittier IPA

I would agree with that.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, that's what I was going to say, most people thought this but some people thought this. I think that that's a reasonable and valuable way to go.

Joe Heyman, MD – Whittier IPA

Right.

Paul Egerman – Businessman/Software Entrepreneur

We don't have to – I don't want to burden Larry with the idea he's got to get unanimity because he's never going to get off this slide.

Joe Heyman, MD – Whittier IPA

Well, I would agree with that, but this is a proposed area for certification. I would say this is an area that –

Paul Egerman – Businessman/Software Entrepreneur

Well, I think that there is disagreement.

Joe Heyman, MD – Whittier IPA

– to certification.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and so there is disagreements and hopefully –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, I clearly hear that this is contentious and as I think I made clear during the presentation to the Policy Committee back in January, was it only January, no it must have been December, that there was a lot of contention in the Workgroup around several of these topics. So, I don't plan to hide the level of lack of consensus.

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

Well, excuse me, this is Joan and as one of the few other Workgroup members on the call I would like to say that I am very much in favor of this and I think that this is one of the best ways we can maximize and optimize the use of EHRs. So, just to give my little vote there.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

And this is Michelle, I do want to add as well, I think when you're able to align it with existing requirements and increase efficiency by pointing to standards that's been a desire of the collaborative as well and through their roadmaps.

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

And this is Jennie, I just wanted to also voice my support for this recommendation as well.

Paul Egerman – Businessman/Software Entrepreneur

And in looking at this who are the Workgroup members who are saying that they support it, I know Joan is are the others Workgroup members?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, Jennie is for this round of work as well.

Paul Egerman – Businessman/Software Entrepreneur

Okay, great.

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

This is John Derr, I support the work on quality but I also happen to agree with some of the other comments. There are so many other people, and I'm on the Workgroup, so many other people looking at this but to me it's the snake in the woodpile as we get person centric, electronic, longitudinal care.

But, I also agree with Paul who said – because we just – I have a file called piling on which has all the different quality measures that we keep asking us to do by different groups and I agree with what he said about this and somebody's got to take the leadership in quality measures and as far as I can see I don't think anyone has.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and John the piling on occurs at multiple levels too on the quality measure side, you've got all kinds of state regulations, you've got – it's frustrating.

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

Yeah, I know believe me –

Paul Egerman – Businessman/Software Entrepreneur

And it's frustrating.

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

We even have it down to the county level.

Paul Egerman – Businessman/Software Entrepreneur

Oh, absolutely, or down to the city level.

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

Sure.

Paul Egerman – Businessman/Software Entrepreneur

You know, it's an amazing thing the things that you have to produce, the reports that you have to produce.

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

It's also penalty management type of management too it's not person centric over the spectrum of care and longitudinal and chronic care too, it's disease management focused –

Joe Heyman, MD – Whittier IPA

Well, this is Joe, I would have liked at least to indicate that it should not interfere with the workflow.

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

Agreed.

Joe Heyman, MD – Whittier IPA

I don't see it there and I just want to make certain that it appears there when it goes to that other Workgroup, because they never think about workflow they only think about what they want to accomplish.

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

We can certainly – this is Liz from ONC, we can certainly make that caveat when we make the request.

Joe Heyman, MD – Whittier IPA

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Thank you.

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

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Let's go onto the next slide.

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

Hello this is Mike Lardieri?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes?

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

Yeah, hi, yeah I was on mute so I couldn't get in, so I just have just a comment on this whole thing because this is one of the recommendations we'll be making from behavioral health is that possibly the certification process should be tiered so interoperability would be first and then quality measures would be next.

I'm not advocating for new quality measures but I think quality measures are important especially if you're going to play in a shared savings environment at all you need to be on the same quality measures as everybody else.

So, having a vendor certify that they meet the same quality measures or can produce the same quality measures or at least the data that will match and what Paul was saying about using middleware to do it, I don't have any problem with that, but the data would have to be structured in a certain way so it would work. So, I would advocate that I think that would be a good thing to have quality measures included.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

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

Thanks.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

No lack of intensity on this topic.

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

No, no.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Privacy and security, thank you, thank you Mike for getting mute off. Privacy and security, Liz you want to say what we heard from the – at the hearing?

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

Absolutely, so these are comments from the panelists and I'm going to just raise two high level bullets here and one was – the first one is that there was a general sense that there should be an overarching standard around security and privacy.

And one of the panelist stated specifically that they had an IT department – if their IT department had not evaluated their EHR software that they would on a daily basis have been in breach of HIPAA.

And they also noted that most LTPAC providers have small IT departments and don't have the time or skill to evaluate software at the level needed to secure, a safe company and patient data. So, that's it.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so proposed areas for certification, so we've pulled out from the existing criteria several of the individual elements with the thought that we could go through these and sort of give a thumbs up or a thumbs down that in fact these were important for addressing privacy and security. Does that sound like a good approach to you guys?

Paul Egerman – Businessman/Software Entrepreneur

Yes –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay. I'm just not used to silence I guess I should have moved on, silence means "yes." Okay, so authentication, access control and authorization seems like a building block.

Paul Egerman – Businessman/Software Entrepreneur

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

As well as auditable events, tamper resistance.

Paul Egerman – Businessman/Software Entrepreneur

What does tamper resistance mean?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I don't know the specific what's in the criteria.

Paul Egerman – Businessman/Software Entrepreneur

But this is just repeating what's already in the criteria?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

All of these are intended to be repeating what's in the criteria, so I'll have to ask ONC to verify that so we didn't –

Joe Heyman, MD – Whittier IPA

What does optional mean? It says optional accounting of disclosures. Either you certify for it or you don't.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I believe in the current – because of the – I don't think we even have a final rule yet on accounting of disclosure.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, why don't we keep going through these Larry and then I'll talk about that when we get to it.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay. Well, let's just jump ahead to that one. So are there any other – are there any other ones between here and there?

Paul Egerman – Businessman/Software Entrepreneur

Well –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Between tamper resistance –

Paul Egerman – Businessman/Software Entrepreneur

Well, the question of amendments is a complicated issue.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

Paul Egerman – Businessman/Software Entrepreneur

I think that's in Meaningful Use Stage 3, I don't think that's in 2 although I might be wrong on that.

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

All of these are in Stage 2.

Paul Egerman – Businessman/Software Entrepreneur

There all, so amendments is already in Stage 2?

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

That's correct, this whole list is from Stage 2.

Paul Egerman – Businessman/Software Entrepreneur

Okay, then I'm fine with it. And then the issue of accounting of disclosures as to how it can be optional, optional the way I understand it is optional means optional so that you can be certified with it or you can be certified without it, it's up the vendor's choice, because there's a lot of – the reason why it was done that way I think was there was a lot of policy questions about how to do it correctly. So, that there is – there is sort of a standard but I think very few people are using it. So, I hope that answers your question Joe.

Joe Heyman, MD – Whittier IPA

I guess so.

Paul Egerman – Businessman/Software Entrepreneur

So, to get back to this basic list, assume that they're all in Stage 2 my view is that this is fine. I have two comments though, one is the title of the thing is privacy and security and these are really all security. I mean, the reason I say that is somebody was talking about the hearing about being HIPAA compliant, doing these things does not inherently make you HIPAA compliant it's sort of like its – these are things that are necessary to do but they're not sufficient.

To be HIPAA compliant, to have privacy involves a lot of things around policy and we need to be very clear about that, this was just a minimal set of security and I suppose you could call them integrity capabilities but it's not really all about – necessarily all about privacy or HIPAA compliance.

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

This is Sue –

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

Paul is AOD a privacy or security issue?

Paul Egerman – Businessman/Software Entrepreneur

Pardon me?

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

Accounting of disclosures is that privacy or is that a security issue?

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I guess you – that is – I suppose you could consider that a privacy kind of an issue but it is an optional thing and I suppose you can call automatic log-off a privacy thing too, but –

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

Well and this is Sue and –

Paul Egerman – Businessman/Software Entrepreneur

I'm just trying to make an observation that this – a lot of people think you're doing this and now you're HIPAA compliant, you've satisfied everything you need to do for privacy and security.

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

Yeah, not so.

Paul Egerman – Businessman/Software Entrepreneur

I'm just saying, no, this is the simple stuff, you know, it would be correct with the exception of accounting of disclosures, but if you take that off the list, because it is optional, this is the simple easy, technical stuff to do, is that's a baseline, but that doesn't mean that you shouldn't do it. We should just make sure we understand what we're doing.

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

Okay, and this is Sue, if I can just jump in real quick. So, the privacy and security title is directly out of the rule itself as it was published in the Federal Register and I'm assuming that part of the issue we're talking about there is because components that you're seeing on this list are either in the HIPAA Security Rule or in the Privacy Rule, amendments is in the Privacy Rule.

I mean, as you were mentioning the accounting of disclosures is also in the Privacy Rule. So, I'm assuming that that's part of the rationale for the naming of this.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, well, and again, my other comment was – reason is in the summary of the hearing people said they want to be HIPAA compliant and that was actually said in one of earlier meetings and certification by itself does not cause you to be HIPAA compliant.

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

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think we're all –

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

Yes, perfect.

Paul Egerman – Businessman/Software Entrepreneur

...I think this is fine, I don't think anybody disagrees.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Great, any other comments before we move on to the next one? Let's go onto the next slide.

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

Okay, so these are comments from panelists, that electronic exchange of standardized interoperable clinical information between different IT platforms becomes the essential tool for care integration between and among the acute and LTPAC providers.

Panelists also said that as they experience care transitions interoperability will lead to efficiencies and another panelist noted that at minimum EHR certification for both eligible providers and LTPAC sites should include the capacity to send and receive the standardized data elements in the HL7 Consolidated CDA to support transitions in coordination, that's it.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay and so we picked up again the language out of the – so the first bullet, I guess I should say because we missed an edit here, the first bullet is based on the existing certification criteria, supporting, receiving, display and incorporation create and transmit summary of care records.

So, I assume that's at the heart of what we've been talking about when we talk about information exchange and the importance of interoperability and improving transitions of care. So, any comments about the first bullet here?

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

I'll just clarify this comes from MU2.

Joe Heyman, MD – Whittier IPA

This is Joe, I think it's great and I would just like to say I wish that our EMRs were able to do it and they're not.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul I just want to say I agree, I think it's great, I like it.

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

This is Jennie I also agree.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Amazing, we have agreement.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and I'd just say I'd go further and say for that one bullet is, in my opinion, at least the guts of the entire certification effort. I mean, if we accomplish this we're probably accomplishing 80 or 90% of the value of certification in that one bullet. I think –

Joe Heyman, MD – Whittier IPA

Right and my concern is –

Paul Egerman – Businessman/Software Entrepreneur

This would be huge step forward, huge step forward if we can accomplish this.

Joe Heyman, MD – Whittier IPA

Because we concentrate on everything else we haven't accomplished this.

Paul Egerman – Businessman/Software Entrepreneur

Well, that's the fear or you put too many other things on to pick up on John's comment of piling on, you pile on so many other things that vendors don't want to do the entire certification process so that's how you miss this one. But this is the thing, that one bullet, we do this, this is huge, we should be able to do a victory lap.

Joe Heyman, MD – Whittier IPA

And this will really change healthcare.

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

This is John Derr –

Joe Heyman, MD – Whittier IPA

A lot of those other things are doing a lot of extra work that don't change much.

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

This is John Derr and a number of the vendors can do CCDs and are working on the CDAs but some of the vendors have told me that they've tried to exchange a CCD with a hospital and the hospitals are unable to receive it.

Joe Heyman, MD – Whittier IPA

Right.

Paul Egerman – Businessman/Software Entrepreneur

Your right.

Joe Heyman, MD – Whittier IPA

You're absolutely right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes and I think we're now in a time transition right? We're looking at a lot of this being clarified in MU2 and MU2 has just begun, right? So the systems that are MU2 certified will be able to receive CDA documents.

Joe Heyman, MD – Whittier IPA

Well, that's what they say.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's what they say, you're right. I can't go beyond what they say at this point it's too early, it's too early to argue facts because we don't have any.

Joe Heyman, MD – Whittier IPA

Exactly, when it happens I'll be the happiest person on earth.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, I'll take you out for a victory lap. I might even be in your neighborhood week after next.

Joe Heyman, MD – Whittier IPA

No kidding?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, that's another story.

Joe Heyman, MD – Whittier IPA

All right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so the next one actually should be in red because this is building on future, correct? My ONC buddy?

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

Yes, yes that's correct.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes. So, there is some new work on transitions of care that's just been through an HL7 ballot and is currently in ballot resolution and my understanding is that it's going to be part of the MU3 criteria but I don't know how far down the pike they are with that.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah and so that may be, but I would say we don't need to go that far. First of all the fact that it's only as far as possibly a ballot is frightening, right?

It's sort of like you've got something new that people think is good but hasn't been implemented anywhere yet and I don't think you should you go there at least not yet.

Let's stick with the first bullet and we don't have to say what we're going to do in the future. In the future we'll see what it looks like and we'll decide then.

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

This is Jennie Harvell, I actually disagree with that for a couple of different reasons. One, we heard from several subject matter experts during earlier hearings on the importance of the emerging TOC and care plan standards in the Consolidated CDA that's being reconciled now and those subject matter experts, you know, physicians and nurses talked about the importance of the content in this Consolidated CDA including the care plan specification to support the workflow and clinical information needs in long-term post-acute care.

The second reason I disagree with that is it's my understanding, and perhaps I'm not correct about this, but I believe once this Workgroup makes its recommendations to the Policy Committee and the Policy Committee makes its recommendations to ONC, ONC then will develop an NPRM, so of course this process takes some time, but through that NPRM process then we'll seek public comment on the viability of including this kind of criteria and the clinical utility of it. And I think for both those reasons I support this particular recommendation as well.

Paul Eggerman – Businessman/Software Entrepreneur

Again, I have to say, the reason I'm opposed is, in my mind it is irresponsible to try to do a rollout on a national basis on any standard or technology that isn't currently in operation. I mean, just – a lot of things look really great on paper but when you try to put them in operation something goes wrong, something always goes wrong and so the very fact that you have something that's at a point where people are just voting on whether or not they think it's a good idea, that's not ready for primetime, it's not close to being ready for primetime.

It's not going to be ready for primetime a year from now. It's got a lot of work to go before it's ready for primetime and we shouldn't be including that in the certification criteria. We should put in certification something that works otherwise you undermine the whole program, you put something in place it doesn't work, it's really hard to change it after you issue that NPRM, after you issue that proposed rule.

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

So, I'm not a vendor but I understand and at least am empathetic about the challenges of that and agree in part with what you say, however, two things, one the Consolidated CDA was adopted in Stage 2 after it concluded its reconciliation I believe in either June or July and the rule went out in July. So, you know, there is some past precedent for this going forward at this point.

And the second comment I would make is that there are some communities that are piloting, for example the care plan specification that's in the Consolidated CDA that went out for ballot. So, there is some piloting work that's happening that could inform I think an NPRM and comments on an NPRM on this point.

Joe Heyman, MD – Whittier IPA

This is Joe, I have a question, for Meaningful Use 1 was there a requirement for a CCR or a CDA?

Paul Egerman – Businessman/Software Entrepreneur

I think you had a choice, I think.

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

Joe Heyman, MD – Whittier IPA

And none of them work or at least they don't work very well. So, I'm just concerned – that's why I'm being cautious about the C-CDA, which I would love to have work perfectly, but I'm just cautious about, you know, everybody bought certified software thinking they could communicate with each other and nobody can. So, there's not much point in putting a whole bunch of stuff in that doesn't really work yet.

Paul Egerman – Businessman/Software Entrepreneur

Or we don't know if it works is a better way of saying it.

Joe Heyman, MD – Whittier IPA

Exactly that's what I'm saying. We don't know, but at least the C-CDA is something that's been approved, etcetera so I can see putting it in there. And frankly, I think that anybody who wants to sell long-term care people a product that doesn't include reconciliation or coordination of care is not going to be able to sell it. So, I don't know why we would certify for standards that haven't been created yet.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so at this point I'd say we have disagreement on this bullet some will be ready and others who are not ready and in fact unwise to pursue this bullet, the second bullet.

Joe Heyman, MD – Whittier IPA

On the second bullet, the first bullet I think we all agree on.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, yes, agreement on the first and disagreement on the second. Okay, let's see where we are on the next slide. So, clinical summary as one of the document types.

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

Yes and so we heard from the hearing that LTPAC organizations are being pressured by receiving eligible hospitals for better information and getting pressure from these hospitals to be part of the system and that the focus of the LTPAC EHR certification should be to support transitions of care and that standards used in Meaningful Use such as Consolidated CDA, SNOMED, LOINC and RxNorm can be and are supported within EHR products to help obtain greater parity in the exchange of information regardless of formal certification and that's it.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so the clinical summary is one of the CDA document types that is called out in the MU2 certification criteria and standards and so this is directly mapping to that.

Joe Heyman, MD – Whittier IPA

I'm in favor of this.

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

Larry do you want us to say something that we favor these things each time or how do you want to work that?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Sure, why don't we – if you're in favor chime in. Thank you, John.

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

I favor this.

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

It happens so seldom but I favor.

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

Can you say your name so I can record it?

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

This is Marc.

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

Thanks.

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

This is Joan and I'm in favor and I was actually in favor of the last one as well.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Thank you.

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

This is Jennie, I agree.

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

I'm sorry, this is Elise, Joan were you in favor of the second bullet as well, I didn't hear that part?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

We haven't talked about – the second bullet here is – we're talking about the clinical summary.

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

On the previous – yeah, Joan had mentioned that she was in favor of the previous slide and I wasn't sure whether that was both bullets or just the first.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Oh.

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

I was speaking of the contentious bullet.

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

The second one as well, okay, thank you.

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

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, we're contentious on the contentious item on picking up new standards and we're okay on the building on current looks good. The comment here in red is that Meaningful Use Workgroup is also looking to move this in Stage 3.

Paul Egerman – Businessman/Software Entrepreneur

So, I'm confused about that comment. Is what you've shown here is that already in Stage 2 or is it not in Stage 2?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Clinical summary is already in Stage 2.

Paul Egerman – Businessman/Software Entrepreneur

Okay, so what does this bullet, thing in red mean?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I don't know what –

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

Oh, there is – this is to say there is an update, that the Meaningful Use Workgroup is updating this and that there is an update forthcoming. So, when that update arrives will you be like – will this Workgroup be in support of that.

Joe Heyman, MD – Whittier IPA

Well, how would we know –

Paul Egerman – Businessman/Software Entrepreneur

Well, it's hard to know because I don't know what it is.

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

Well, in support –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I guess this is the other problem with putting standards into Regs right guys? They're constantly changing.

Paul Egerman – Businessman/Software Entrepreneur

Well –

Joe Heyman, MD – Whittier IPA

–

Paul Egerman – Businessman/Software Entrepreneur

It's actually a problem with the structure. Because the Certification Workgroup has really never before, at least not that I can recall, made specific certification recommendations, we've really been involved with the certification process –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare
Right.

Paul Egerman – Businessman/Software Entrepreneur
As opposed to that.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare
Correct.

Paul Egerman – Businessman/Software Entrepreneur

The specific Meaningful Use and certification recommendations really derive primarily either from the Meaningful Use Workgroup or sometimes from the Information Exchange Workgroup in terms of where their stuff came from.

And, so, now we're adding ourselves as an additional group making these decisions, because those groups really aren't involved and that's why you've got this phenomenon that I call bumper cars, but it just seems to me we need to know more, we can't just say "yes, whatever they say is probably right."

Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology
So, this is just a note to say that there is an update forthcoming.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare
And I guess everybody's point we can't endorse or not endorse something if we don't what it is.

Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology
Okay, so this is just maybe we'll circle back on this one, because we don't know what it is, but maybe on the first bullet it sounds like we have agreement.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, I think the message that the Workgroup is seeming to communicate pretty clearly is where we're building on existing Stage 2 certification criteria that that's in line with where we want to go and where we have extension beyond that it's contentious to completely oversimplify but that's what I'm hearing.

Paul Egerman – Businessman/Software Entrepreneur
Yes, plus it's particularly contentious if we don't know what it is.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare
And – yes, and I think all of us, even those who want to be not contentious would agree that if we don't know what it is we can't really agree to it.

Paul Egerman – Businessman/Software Entrepreneur
Okay.

Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology
Okay, so the note there is that we'll follow up and find out what it is.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare
We'll follow and in fact we may wind up dropping it from our discussion if it's going to still be vague in another month.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Just to give an update the Meaningful Use Workgroup will be bringing their recommendations to the Policy Committee on February 4th.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare
Oh, boy.

Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
So, after that time perhaps we could share what has been finalized and update the slides as appropriate.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That will be an intense meeting, February 4th meeting. Okay, let's go onto the next slide. Data portability.

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

Okay, so data portability from the hearing we heard a recommendation for the establishment of standards and incentives to help long-term care service providers adapt their existing EHR system or purchase a new one that meets requirements for interoperability, transfer of information and enabling monitoring for quality.

Another panelist noted support for standards used in Meaningful Use, again this was noted before such as the Consolidated CDA, SNOMED, LOINC, RxNorm, that could achieve greater parity in exchange of information regardless of formal certification. And those I think were all the comments from the hearing.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul Egerman I'm going to speak out opposed to this. I actually opposed it also for Meaningful Use. The issue here is simple, first of all, in my opinion it's just not practical to write a standard for moving data under all circumstances for all entities to some other, you know, some other vendor's system.

The concept of data portability is that you can buy some other vendor system and somehow easily move your data to that new system and it's just not a practical thing to accomplish for a lot of different reasons and so that's my first reason.

The second comment is like my other thing, it doesn't exist, this is even further away than HL7 there has been nothing balloted on it. There is just a ton of work that would need to be done before this would be ready for primetime.

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

Okay, this is Sue –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, this is Larry, let me jump in, my understanding is that while the title here is really broad, data portability, the actual certification criteria is about the ability to create bulk C-CDAs and to also be able to receive bulk C-CDAs. It doesn't speak to whether or not you're actually able to encompass the entirety of the medical record.

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

Right, this is Sue, if I could just jump in Larry? You've summarized it well except that it actually only addresses the ability to create these export summaries and you're again creating a Consolidated CDA as you have to for transitions of care or for the clinical summary that we just talked about and you have to be able to represent the data elements as identified in the common Meaningful Use data set which is again the same core set of data items that show up in these other summaries that we will be addressing. So, there is really nothing really unique about this requirement except to be able to do it for a bulk of residents.

Joe Heyman, MD – Whittier IPA

For what, I'm sorry say that last thing?

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

Oh, I'm sorry, except to be able to do it as it says, for all of your residents, that you have the capability to create these Consolidated CDAs.

Joe Heyman, MD – Whittier IPA

And why is that different from the previous bullets that we just approved? I'm not clear on what the difference is.

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

So, on the clinical summary the only – there is a slight different there, again you have to be able to represent the common Meaningful Use data set but they also have a couple of additional items relevant to an episode of care, so they want to be able to have you capture, you know, the provider's name and contact, the date of, location of the visit.

So, there are a couple of additional specific items that go into that clinical summary that would be different than what goes into this Consolidated CDA that you're creating as an export for all of the residents.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, the difference is –

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

It's more episode specific.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, the difference here from the earlier one, the earlier one is you're one by one creating these as part of caring for an individual, in this case you're potentially creating a batch for all of the patients.

Joe Heyman, MD – Whittier IPA

I see, I see. Are you requiring –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

–

Joe Heyman, MD – Whittier IPA

Are you required to receive a batch?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Sue was pointing out that the requirement is only that you create them not that you can bring them in –

Joe Heyman, MD – Whittier IPA

Well, why?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Which is a little bizarre.

Joe Heyman, MD – Whittier IPA

Yeah. Why create a requirement that nobody is capable of receiving, I don't understand that?

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

Well, you know, in thinking of it I may missed something, but as I'm looking at, you know, this one component of the rule that talks about data portability it specifically addresses creating a set of export summaries.

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

This is John Derr –

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

And it gives you what data items have to be included.

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

This is John Derr, is this pertaining to the fact that we're supposed to keep the loved ones and the primary physician informed about what we do in a nursing home?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

No.

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

No.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, I take that back. I'm a little too broad in "no." Some of the commentary on data portability includes that this is available for patients as well, one of the use cases is patients changing providers and wanting a summary of multiple encounters.

Joe Heyman, MD – Whittier IPA

This is a function of the health information exchange that's why we need them it seems to me.

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

Yeah and if I can just add to my previous description about this Consolidated CDA, it also includes, for data portability, there are like six additional items that you're required to do for transitions of care that talks about immunization, cognitive status, functional status so it's basically the same Consolidated CDA that you would have to create for transition of care purposes. They just want you to be able to do it in bulk.

Joe Heyman, MD – Whittier IPA

But that's something I don't understand. I mean, I think it's great to have the C-CDA and I think it's great for it to be standardized, and I think it's great for it to include all of those things you just mentioned. What I don't understand is why you would send something that nobody can receive.

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

This is Jennie and my guess is, and maybe we can ask if ONC could check out the –

M

–

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

Of their previous rule and I'm sure there is a discussion on this point – back to this Workgroup.

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

Hi, this is Elise, my suggestion would be that, you know, we at ONC can take a look at this and report back for the next group as Jennie said and then we can move onto the next one for now and bring this one back up on the next call. Would that work?

Joe Heyman, MD – Whittier IPA

Sure.

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

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, thank you. And...

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

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It looks like the other two that are in red as part of MU3, right?

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

Yeah, they were part of – already included in the transmittal letter.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

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

Okay, so and Larry if I could just add one other thought about our discussion on the receiving capability. At the point that we get into the discussion about transfer of care summaries –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

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

It does say that you have to be able to receive a Consolidated CDA that has those exact same requirements.

Joe Heyman, MD – Whittier IPA

Yes, but not a batch, but not a batch.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It's the batch piece.

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

Well, that's – you know, I mean, but again when you're doing a Consolidated CDA it has to be for an individual because of your header.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

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

So, at any rate – so, again I think we need to leave this, you know, with ONC getting us the clarification but I just did want to mention that the rules do explicitly talk about receipt of Consolidated CDAs but it's in the context of another type of transaction.

Joe Heyman, MD – Whittier IPA

Yeah, I think that would be wonderful especially if they could actually receive them as dedicated fields instead of as a PDF that would be a wonderful thing.

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

Well, I think that's – I have to agree, yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I'm fighting those same battles for what it's worth.

Joe Heyman, MD – Whittier IPA

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Let's go onto the next slide. View, download and transmit to a third-party.

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

Okay, so what we heard from the hearing was the panelists noted that as we view, download and transfer the providers should protect information but the patient should direct it. So, the work being done in Blue Button would have a great application in transitions of care in LTPAC.

The need to have one record that all parties can tap into, upload to, download from right through to the end of the person's life and one other note was that downloads from discharge records and EHRs could eliminate data entry and facilitate medication reconciliation and that's it.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so again we have things that are based on MU 2 to provide secure online access to health information to patients and authorized representatives, so to John Derr's earlier question, this is the piece about patient engagement, to electronically view, download their EHRs.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul, I guess I'm going to speak as being opposed to this and the reason I'm opposed is that to me the value of what we can do is within transitions of care, this is adding something to the certification process and to the EHR system that I don't know whether or not these exist right now but it's adding a lot of stuff.

This is not a simple thing to do, to get this all right and I think we should focus on the information exchange and the transitions of care and this is what I would call piling on. It's not that I'm opposed to view, download and transmit but in the context of what we're doing I think it's too much.

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

This is John Derr, I agree with Paul, I mean, I know we have to do this to the loved ones and there are portals out there but I think our goal is in transitions of care and that's what we ought to stick with.

Joe Heyman, MD – Whittier IPA

And this is Joe, I would just say that there will be health information exchanges that will be able to do this and so if a long-term care facility is connected to a health information exchange then patients will have a portal in which they can do this from. Why require it in their individual EMRs I don't see it.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

This is Michelle, I just want to point out that not all health information exchange organizations allow patient access. And just to point out that it is a significant communication process to keep authorized family and other representatives up-to-date on clinical information. So, just wanted to add that in.

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

And this is Joan –

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

Please note that was Michelle Dougherty for the record and Michelle can you use your last name?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

Yes.

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

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Joan go ahead?

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

This is Joan and I'd like to say that I agree with Joe on this one.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so you guys are saying this is adding complexity, use other methods for now, right?

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

Yes.

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

Yes.

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

But this is Jennie, I recall some time ago and it might have been with Meaningful Use Stage 1, when the Health IT Policy Committee was making recommendations it created a table and in the table it said, you know, here are the areas that we're recommending to be implemented now and then there was – I don't know if it was columns or rows where they said, here are areas, topics to be addressed at a later point. I would like this concept to be carried forward, perhaps not for now, but for going forward in the future.

I think exchange with family members is very important. We're talking about people who are receiving care for the long-term and whether they're in one setting or multiple settings receiving care from multiple providers the ability to communicate with the family, the patient and their family members not only during a single episode but over time is really important for these individuals and so –

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

And this is John Derr, I agree wholeheartedly with Jennie, there ought to be a way we can sort of put things in parking lots or something so this might be the first stage of something but not –

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

Yes, we can note that, this is Liz from ONC, we can certainly note that.

Joe Heyman, MD – Whittier IPA

I just want to say, this is Joe Heyman, I just want to say one of the problems with patient portals is that there are individual ones for each entity that the person goes to and it becomes very difficult for a family member to be managing all those portals.

So, one of the advantages of health information exchange is that it's a single portal that cuts across all of the vendors and all of the entities, the healthcare entities that the patient interacts with so there is one place where a person can go to get all the information.

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

I don't think anyone –

Joe Heyman, MD – Whittier IPA

And so that's why I think –

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

Is disagreeing with you Joe it's just that not all of our – everybody is in an HIE and maybe in a –

Joe Heyman, MD – Whittier IPA

I understand that but what I'm – but by putting everybody – giving everybody the ability to make a Consolidated CDA that can also be received, everybody will find it much easier to become part of a HIE.

And so, I just – I hate to require things from individual EMRs – it's the same with the measurement stuff, I hate to require individual things from individual EMRs that don't have to do with record keeping that other vendors could do with the same data. And that's the reason I feel the way I do.

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

I think most of the vendors – because I know in my work as a provider, we are providing the family members because we – electronic access to certain amount of information that's in – maybe in the EMR or also some are doing it within the MDS or OASIS assessments.

So, like Jennie said, it's extremely important because sometimes in today's nuclear age the families are a long distance away from their loved one and so that's – we have to do it.

So now the question is Larry do you put it in here now or where do you put it, but they're going to do it anyway. But, whether we need to have certification I guess is the point.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and that's, this is Paul, that's the issue. I'm not arguing that this isn't important to do, it is important to do and it would be very helpful for family members in a lot of situations to be able to be informed. There is just – it's just an issue of timing to me the focus should be on transitions of care.

I also have a suspicion that with an extended care facilities where the basic design of view, download and transmit function is primarily going to be used by family members not by the patient. So, there might be some design aspects to it that are different.

But, I mean, having said that, I think to say, let's defer this to a future, put it in some sort of a parking lot list that we think is important, to say it's important to do, but we are just not ready to do it with our first version of certification.

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

So, it sounds like we have consensus on the parking lot is that right?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes, yes. I'm going to ask a different question guys, maybe someone knows the answer. There is a HIPAA requirement if you've got an EHR to provide electronic copy, right?

Paul Egerman – Businessman/Software Entrepreneur

I'm sorry, say again, Larry, you broke up?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

There is a – sorry, there is a HIPAA requirement to provide electronic copy, is that correct?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

Electronic summary, this is Michelle Dougherty.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Electronic summary of a chart, right?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, are we actually being – are we, you know, I guess the question is – I guess what I'm really asking is across the multiple options that ONC has put in for Meaningful Use Stage 2 for people to get copies is that going to show up somewhere else in this sequence?

It seems like if we're encouraging the provider to adopt the record and they're going to be under a requirement to produce a copy, an electronic copy to give someone that that capability should be in there although the method by which it's done is maybe open-ended, I'm pretty sure HIPAA doesn't tell you the method they just say "you need to be able to produce a copy."

Joe Heyman, MD – Whittier IPA

It isn't an exact copy I don't think.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right, I believe it's –

Joe Heyman, MD – Whittier IPA

I think it's a summary.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

A summary, I believe the comment about it being a summary is correct.

Joe Heyman, MD – Whittier IPA

Right, so that's one of the other advantages of an HIE you can get the summaries from everybody through one place. And I guess one of the reasons that –

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

Yeah, but you've –

Joe Heyman, MD – Whittier IPA

It's more acceptable to have a patient portal on these is because there is an incentive program that says that you have to be able to do it if you want to get your money. So, we don't have any resistance to having a patient portal on our HIE.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Got it, okay, well and I think your HIE is an exception, I don't know of any others that support a patient portal.

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

Does the PHR fall into any of this or am I introducing something –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

The personal health record could be the third-party I believe.

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

I just got a memo from HealthVault telling me what –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay. So, let's table my question about HIPAA for my ONC buddies to research and what I'm hearing is we have consensus to table this as not as important as the transitions of care. So, let's move on, let's see if we can get one more in before we call it quits for today. Patient specific educational resources.

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

Okay, so what we heard was that 75% of long-term care is provided by families in the home and by non-licensed personnel and agencies going into the home and that we need to figure out the presentation layer that appeal to patients and families and again, this notion of having one record that all parties can tap into to upload, download from right through the end of life. And that's everything that's relevant from the hearing.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

Joe Heyman, MD – Whittier IPA

So, I'm not hearing that patient specific education, I'm assuming that's like handouts without particular topics.

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

There might be, this is John Derr, there might be some education on therapy and also real true medication management type of things for educating that requires, you know, the patient to be informed and actually in the future to see goals that they have to achieve and possibly feedback to the physician, but that would be future.

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

Yeah, the current requirement is patient specific education resources based on data included in the patient's problem list, medication list and lab tests, and value results.

Joe Heyman, MD – Whittier IPA

So, this is Joe, this is one of those measurement things, in order to do that we have to have a way for the EMR to measure that we actually gave the patient something. Most doctor's offices have pamphlets and things like that which they hand to patients and then there would be an extra step where you have to record that you gave it to them. It seems to me –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, in this case – Joe, so in this case the lack of Meaningful Use actually could be a benefit, right?

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

There could be the ability in the system to print something but you wouldn't necessarily be having the extra step of demonstrating that you printed it.

Joe Heyman, MD – Whittier IPA

Yes, but we also have that ability in our system, there are certain educational materials that are included in these EMRs but they're not nearly as good as the pamphlets that are sitting right there.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Got it.

Joe Heyman, MD – Whittier IPA

And –

Paul Egerman – Businessman/Software Entrepreneur

I also suspect that depending on the setting some of this material already exists. So, if you're going through hospice care I'll bet they give you a lot of material for the patient and their family members about what it all means and what's going to happen. And so, I'm not sure what I think about this. Again, I'm still focused on transitions of care.

Joe Heyman, MD – Whittier IPA

I think it's really important –

Paul Egerman – Businessman/Software Entrepreneur

And I don't to what extent this adds additional complexity or not.

Joe Heyman, MD – Whittier IPA

I guess the point I'm trying to make is I think it's really important to have information available for patients and for their families but I'm not sure that the EMR is the vehicle for doing it, that is my point. We're asking too much of an EMR and we keep asking for it to do more when there are other ways to accomplish the same thing.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Not only other ways – other ways that –

Joe Heyman, MD – Whittier IPA

Maybe better.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Your assessment is "are better."

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

On the other hand certain vendors and providers may wish to use their EMR/EHR to identify these important patient educational resources.

Joe Heyman, MD – Whittier IPA

I wouldn't argue with that, but what I'm saying is it shouldn't be a certification requirement.

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

Well, we're talking about –

Joe Heyman, MD – Whittier IPA

I agree with you 100%.

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

Right and so what we're talking about here in contrast to the Meaningful Use Program for eligible professionals, which require eligible professionals to use technology for certain purposes to receive their incentive payment, we're not talking about that here.

What we're talking about is a voluntary certification program and including criteria that would be clinically useful, appropriate, I'd have to go back and look at the first slide, one of the first slides in today's deck, so is this an important function in long-term post-acute care and I would say "yes" and I would say it would be nice for certification criteria to support this function.

Joe Heyman, MD – Whittier IPA

And I would disagree.

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

And if vendors and providers use it going forward there will be a certification criteria there.

Joe Heyman, MD – Whittier IPA

I would disagree because it doesn't tell you how good the material is it just tells you that there is going to be material available. I just – this is – I think it's going beyond what's necessary, I don't think it's right for Meaningful Use and I don't think it's right here.

Paul Egerman – Businessman/Software Entrepreneur

And I, this is Paul, I'm not sure what I think but I guess I agree with Joe. I mean, the fundamental issue is I don't know what the state of the art is right now whether or not it's provided but I suspect a lot of this material is already provided and I kind of view this in the same category as a view, download and transmit function which is, you know, it could be very important, it is probably very important for family members to be informed and a lot of the value probably is going to be for family members but it could be also for the patient, but we don't have to do everything on the first try.

I mean, again, this is not transitions of care, this is something very different. So, I'm not excited about it. I'm not –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

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

So, and this is Sue, and if I could just weigh in just real quick on the last comment from, I believe it was Joe, but, you know, you were saying that's not transitions of care but remembering that there are often times that we are transitioning folks from, especially our skilled units, back to their home setting and having been somebody who had my mother, you know, come back home from a nursing home, you know, it would be nice to know that, you know, that there would be this bundled packet that says "oh, your mom is on warfarin, so, you know, here's the stuff about everything you have to watch for that."

So, I just wanted to, you know, raise the thought that perhaps the education materials can be important at transitions of care when I am going to a home setting.

Joe Heyman, MD – Whittier IPA

This is Joe, I absolutely 100% agree that they are important. I just don't think that the EMR has to be the vehicle.

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

Hi, this is Elise, one thing that the Workgroup might consider is if the EHR is not the vehicle or this vendor system is not the vehicle then is there another system that exists to do this in order to be able to not only document what materials have been shared but to allow the healthcare professionals to look at that at a later time and whether having all of that ability the transitions of care along with the educational resources available in the same place would make the workflow possibly easier but also for the benefit of the patient. So, I raise that as a consideration for the Workgroup to kind of touch on.

Joe Heyman, MD – Whittier IPA

Well, this is Joe, what I object to is having to measure that I handed the patient the piece of information.

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

But this is not Meaningful Use so I'm wondering where the measurement would be. This would just be the ability of the Health IT system to be able to do this. It's not a measurement that would be an MU constraint, this is not that. So, there is not a measurement it's just the ability to do it.

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

Correct.

Joe Heyman, MD – Whittier IPA

To do what to measure –

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

No, no, no not to measure, the ability of the vendor system to be able to retrieve this patient specific education and content. It's not the measurement as to whether it's been used, it's been viewed or dispensed but just the ability of the system.

So, I just want to make sure there is a clarification on that. Where the Workgroup ends up is up to the Workgroup, but I just want to make sure there is clarity in terms of that this is not Meaningful Use. So, it's not a measurement it's just the ability of the system to do this particular task. Larry, do I have that right?

Joe Heyman, MD – Whittier IPA

Yeah –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, what I'm hearing is –

Paul Egerman – Businessman/Software Entrepreneur

Who was just speaking?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

We have – this is – so that was Elise speaking who is from ONC, this is Larry.

Paul Egerman – Businessman/Software Entrepreneur

So, Elise from ONC are you telling us that you don't like our recommendation?

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

Well, not at all I just want to make sure – I'm just trying to echo the point that Jennie has made and Sue has made and they've done a ton of work looking at how – what's in place, what's in place with CCHIT and the functional profile to understand what's out there and I think that the point that they're trying to make that I'm just trying to clarify is that this is not a measurement and there has been a lot of references to measurement in reference to this and it's not that.

This is just certification of the ability to do the task. Now where the Workgroup ends up on the recommendation is another issue, but just understanding what the recommendation would be I think is the first step.

Joe Heyman, MD – Whittier IPA

Well, this is Joe –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, let me try to summarize what I've heard.

Joe Heyman, MD – Whittier IPA

All right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

What I've heard is there is a transition home and going home it's useful to have information about medications, conditions, etcetera that you're going to need to deal with when you are home whether that is to the patient or family.

There is – I think the accurate observation that the quality of the information – I think, the quality of the information is not assured by this certification criteria being met and there is often very good materials that are not electronically available they are printed brochures that are intended as patient education materials that are very effective and –

Joe Heyman, MD – Whittier IPA

And there may be electronic versions of those things –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

Joe Heyman, MD – Whittier IPA

That are usually much more abbreviated and not nearly as good and those are the ones that the EMRs use.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right. So, what I'm hearing is – and also there is the various issues around measurement or not, but in terms of this specific piece that we could say there is a transition home that we have not – and my sense from the committee is that we're not focusing on that as the primary transition we're focusing on transitions among professionals from one healthcare provider to another where we believe electronic capabilities will improve the communication.

And so this is, at best, in the parking lot of next tiered things and then there is a lot of discussion about the relative merits of is this the best way to do something. Is that right?

Joe Heyman, MD – Whittier IPA

Yes.

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

Larry, this is Jennie, I just – I really disagree in terms of your comment about the focus of this Workgroup.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

All right.

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

When we started this long-term post-acute care conversation back in December –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

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

We teed up who are these long-term post-acute care provider settings that we're talking about and that included, for example, home health. And we heard, back in December, about the frequency of transitions which include transitions from institutional providers whether they're hospitals or nursing homes to home

–

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

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

Often with home health and so even if the lens is narrow on information exchange from one provider to another some of those transitions will include people going home where they won't be under 24-hour care by any professional formal caregiver and will often, as we heard from the subject matter experts, receive 75% of their care. And so in order to support the continuity and quality of care on behalf of those individuals – and I don't think the Workgroup here is disagreeing with the importance of patient specific educational materials.

So, I'm really – I think this is an important criteria, it's not a requirement, we're not talking Meaningful Use here and like I say I think it's really important for transitions and continuity and quality of care.

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

Hi, this is Elise, I might encourage – I just want to make sure that we're hearing from all the Workgroup members, it's helpful from ONC's perspective to make sure that we hear the different views. So, I'm wondering if there are others on the call who have any thoughts on this particular recommendation?

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

So, this I Joan and I'm really in favor of this recommendation. I think that from the vendor point-of-view it should be one of the easiest criteria to fulfill and from the point-of-view of the patient it's certainly worthwhile and as far as the quality of the educational material goes there are such good materials available through MedlinePlus and other areas that could be funneled into this and through the EHR that I think it would really help the providers to instantaneously be able to produce educational materials that are suitable for a particular patient doing it through the EHR.

So, the materials are available, it should be easy for the vendor and the patients would appreciate it. So, I really don't see what the big issue is.

Paul Eggerman – Businessman/Software Entrepreneur

And Joan, the – this is Paul, I mean, I don't think it's quite as easy as you might think because there is also a multi-lingual requirement that you have to record the preferred language of the recipient which is either the patient or I guess the family members and you have to be able to produce material in multiple languages.

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

Right, I don't think that's so difficult either.

Joe Heyman, MD – Whittier IPA

I'm just talking about the real world not what's possible. In the real world we get this information which is required by Meaningful Use it's not as good as what is out there in other places and it adds to the workflow, other than that it's fine in the real world.

I'm not arguing with your suggestion that it would be a great thing and that it would be something that – but I don't think asking the EMR to do it is the right answer there are other ways to do it without an EMR.

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

I'm sorry, this is Michelle, we are already 7 minutes over on this call so I think we're going to have to open up to public comment soon. Obviously, I know there is a lot of discussion that could continue so I think we can pick this up on the next call, my apologies, but Larry are we okay to open to public comment?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, I think that would be fine and I actually want to thank everybody for making as much progress as we did today. This was a really good discussion. So, yes, please open it up for public comment.

Public Comment

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

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.

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

We do have a public comment.

Ashley Griffin – Management Assistant – Altarum Institute

Donna go ahead.

Donna Doneski – Director Policy & Membership – National Association for the Support of Long-Term Care

Donna Doneski and I'm with NASL we represent both the IT vendors that serve the majority of LTPAC and care providers, we're also founding members of the LTPAC HIT Collaborative that you've heard from. We did submit comments back last January on Meaningful Use Stage 3 and urged the ONC to require eligible hospitals to coordinate with LTPAC and exchange information on transitions of care because of the potential to improve health outcomes for the vulnerable Medicare/Medicaid patients and the alignment with efforts like reducing re-hospitalization and achieving savings for Medicare and Medicaid.

Our members are intensely focused on interoperability and providing IT solutions that providers and LTPAC can use to achieve the efficiencies they need in the current environment and our vendors have certainly demonstrated their commitment to work with the federal government on voluntary certification starting with CCHIT 2011, 2014 editions and we would welcome the opportunity to work with any of you on all of these items. Thank you.

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

Do we have any more public comment?

Ashley Griffin – Management Assistant – Altarum Institute

We have no further public comment.

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

Thank you and thank you everyone for taking the time.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, just a reminder our next call is Tuesday, January 21st at 11:00 Eastern, talk to you all then.

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

Thank you.

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

Thanks everyone.

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

Thank you.

Public Comment Received During the Meeting

1. Is anyone on the workgroup representing Medicaid community-based long-term services/supports?
2. As a pre requisite for discussing measures, I think it is critically important that the committee define the scope of long term and post-acute care to which they are referring..... 62% of all LTC in the country is paid for by Medicaid; almost half of that is provided in the community; post-acute care is generally in Medicare. It appears the systems to which the work group refers may be a subset of these systems.