

**HIT Policy Committee
Certification & Adoption Workgroup
Transcript
March 4, 2014**

Presentation

Operator

All lines 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. 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.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Hi.

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

Marc Probst? Carl Dvorak?

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Here.

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

Hi Carl.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Hello.

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

Diane Bedecarre?

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

Here.

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

Hi Diane. Donald Rucker? Elizabeth Chapman?

Elizabeth Chapman, MS – Program Analyst – Veterans Health Administration

I'm here.

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

Elizabeth Johnson?

Elizabeth Chapman, MS – Program Analyst – Veterans Health Administration

That was Elizabeth Chapman, I'm here.

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

Thank you. Liz Johnson? George Hripcsak? Jennie Harvell?

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

Present.

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

Hi Jennie. Joan Ash?

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

I'm here.

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

Hi Joan. John Derr? Joe Heyman?

Joe Heyman, MD – Whittier IPA

Here.

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

Hi Joe.

Joe Heyman, MD – Whittier IPA

Hi.

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

Marty Rice? Maureen Boyle?

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

I'm here.

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

Hi Maureen. Mike Lardieri?

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

I'm here, hello.

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

Hello. 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. Paul Tang? Stan Huff? And from ONC do we have Liz Palena-Hall?

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

Here.

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

Hi Liz. Do we have Elise Anthony? Jennifer Frazier?

Jennifer Frazier, MPH – Policy Analyst – Department of Health & Human Services

Here.

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

Hi Jen. Steve Posnack?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yes.

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

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

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, well I'd like to welcome everybody back, I know some of us were at HIMSS and got a big dose of what's happening broadly this week or last week, what's happening broadly in the industry. So part of that was the Friday before HIMSS ONC released a Notice of Proposed Rulemaking so Steve is going to talk to us about that and then we'll get back to our immediate charge of some recommendations to the Policy Committee for next Tuesday, so just to remind people we're sort of in the short funnel here of post-acute long-term care and behavioral health providers and maybe a footnote on anticipate what Steve is going to say.

So, there are elements of the NPRM that I think we're going to want to respond to both in our role as the Certification and Adoption Workgroup because it addresses certification process and there are specific things that in the NPRM talk to behavioral health, long-term post-acute care and specifically about what the Workgroup is doing. So, those will be in the things that we will look at after next week's meeting and get back to the Policy Committee and ONC with recommendations on our response to the NPRM during its public comment period.

We'll also be hearing from the Tiger Team on Privacy and Security addressing some of our issues with behavioral health and the needs for additional consents and then tracking that consent through documents as they move through the system.

And we have one other call this week to wrap things up in advance of our meeting with the Policy Committee and I think that's the framework for today. Let's get started. Next slide. Already done that, next slide, next slide. Steve it's yours.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

All right thanks a lot Larry. I know everyone you have a jammed packed agenda today so I am going to keep my comments brief and be making mostly a cameo appearance so we can go to my next slide.

There are a few elements in the 2015 edition Notice of Proposed Rulemaking that are, as Larry mentioned, relevant to this group and that have set a policy framework for the future. Just a brief overview there is the actual portion of the proposed rule that is the 2015 edition proposed certification criteria which include references to updated standards versions or implementation guides, the actual codification of numerous frequently asked questions that we've issued.

So, really having a formal certification criterion that references the policy commentary that we've already included in frequently asked questions that's kind of the "bug fixing" that we've done as well, in other cases we've, in response to stakeholder feedback, altered some certification criteria in a way that we think provides better approaches for certification as well as additional clarity related to the certification criteria.

And it's important to note that a number of the certification criteria in the 2015 edition are carryovers or proposed "as is" I would say from the 2014 edition. So, this, really for the first time provides a significant opportunity for what we call "gap certification" which is the use of previously issued test results from a prior edition toward the certification of a product to the new edition of certification criteria.

Relevant to the certification program proposal one of the biggest ones is that we propose to discontinue the issuance of "complete EHR" certifications going forward. There is a long rationale provided in the proposed rule so I won't take up my time here to explain that, but, suffice it to say I think we believe that this type of certification has run its course and is causing additional confusion when we could simplify things through our regulatory framework.

There is a concept that we have included in the rulemaking related to the potential creation of what we're calling certification packages and that would be a way where a common grouping of certification criteria could be labeled in such a way to make it easier and more easy to communicate to potential stakeholders the certification criteria to which a product is certified.

I've joked that, you know, not that everyone wouldn't want to become an expert in using the Code of Federal Regulations and understanding the terminology that I use on a daily basis to refer to the CFR and the specific sections and paragraphs, etcetera, but if – like in all other areas of our lives where we have meaningful shorthand, you know, the concept of having packages to clearly communicate a certain grouping of certification criteria seemed like an idea that could be valuable to the industry and that's where we're seeking comment on as well.

And then maybe another bigger distinction that we've gotten among this third hash mark here is the proposal that we've made relative to EHR Modules, capital M, as we've defined the term, to propose a distinction as part of certification that there be separate "Meaningful Use" MU Modules and "Non-MU" Modules."

And so we have taken all of the creativity out of the naming convention here for simplicity, but as we looked at our regulatory framework and those of you who may be familiar with a kind of generic interoperability guidance that we issued I believe in August of last year where we were trying to encourage EHR technology developers for other settings, those that don't necessarily serve customers that are eligible for Meaningful Use incentives, to look at the certification criteria that were available and to see which ones might be relevant to those stakeholders and to seek certification.

As we were going through that process we noticed that when you look at our regulatory framework today it's kind of a closed structure around the Meaningful Use paradigm and what that translated into was a situation where an EHR technology developer who was interested in seeking certification to get their products certified for providers that aren't eligible for Meaningful Use incentives would have to understand the Meaningful Use Program and it's measures and the logic behind the measure in order to get their products certified and that's because for EHR technology as it goes through the certification process we have a certification program policy that EHR technology be able to calculate percentage-based measures for Meaningful Use.

And so in that context we looked at that as a potential sort of regulatory burden that we could remove for EHR technology developers that were aiming for the environments and settings that were not eligible for incentives and so we have proposed in this non-creative distinction to have two different types of EHR Module Certification, one for Meaningful Use and one for Non-Meaningful Use.

The Non-Meaningful Use distinction would enable an EHR technology developer to get certified to a specific certification purely for its functionality and not necessarily to support the specific Meaningful Use Program measure calculation. And that we saw as a way to open our regulatory structure and make the regulatory structure more extensible over time regardless of whether or not we chose to move forward based on the Certification Adoption Workgroup on specific settings. It seemed like a prudent idea to make sure that our current regulatory structure was more open in general.

And so that's a little bit of the basis behind the distinction there not to kind of preemptively jump in front of the discussions that you all are having today. We also mentioned in our section related to the 2017 edition, which would be the next rulemaking that we would go through in support of Meaningful Use policies a broader look at certification and other uses and potential areas.

Some have raised a certification relevant to pediatrics, that's not an area necessarily that, you know, this group has been asked to focus on as an initial priority, but it is relevant to some of the other stakeholders that we work with both in the public sector and private sector as well as our federal colleagues at AHRQ and Medicaid through CMS.

So, that's where we talk more broadly about whether there should be more general potential for health information technology modules, I believe is the term we used, as well as the specific types of healthcare settings and this gave us an opportunity to elicit public comment on these concepts more broadly in addition to the feedback that, the more specific feedback, that we'll be getting from this Workgroup on the two priority areas that we asked as part of your charge. So, I think I can go to the next slide.

Paul Egerman – Businessman/Software Entrepreneur

Can I ask a question, Steve? Hello?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yes?

Paul Egerman – Businessman/Software Entrepreneur

Steve, its Paul Egerman.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Sure.

Paul Egerman – Businessman/Software Entrepreneur

Just a quick question, you have this concept of the package, how many packages? I'm trying to understand how big a package is? How many packages would be in what was formerly called a complete EHR?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well, we don't define the package concept by the complete EHR or we don't have a relationship between the two. We really look at the type of certification criteria.

So, in the proposed rule we noted that there could be a, you know, "care coordination package" which would reference a couple of certification criteria and similarly "patient engagement package" which would reference I think the view, download and transmit to a third-party and secure messaging. If we had other certification criteria that logically grouped in that context then there could be a similarly named package. Does that make sense?

Paul Egerman – Businessman/Software Entrepreneur

Okay, so, okay –

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

It would really –

Paul Egerman – Businessman/Software Entrepreneur

It's not like, it's not like Lego building blocks, in other words it's not like 12 packages fit together to form what was formerly a complete EHR. The complete EHR can be assembled in lots of different ways.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, correct, we're not altering how someone would be able to assemble the EHR technology that they want to use. Really the package concept is more along the lines of kind of a – and I'm sorry to use a standard specific word, but it's the first thing that jumped into my head, a post coordinated way, you know, to say, although we'd identify what constitutes a particular package, so maybe it would actually be pre-coordinated, you know, we could say that the – you know the x, y, and z criteria make up a, you know, medication safety package and, you know, we'd identify what those three criteria are and if an EHR technology developer got certified to those three criteria then they would be able to say, you know, this product is certified to the medication safety package and it would really just be a shorthand way to easily communicate that those three criteria were certified.

Paul Egerman – Businessman/Software Entrepreneur

But each package is going to have to have its own separate security certification and I mean –

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

I wouldn't attribute the packaging is more about communication and not about the capability per se in how they're included as part of a broader product or not.

But, you could have an EHR technology that is say certified to a dozen certification criteria and let's keep the math simply, so let's say we had 3 pre-defined packages of 4 criteria a piece then you would have a single EHR technology that was certified and they'd be able to say in shorthand, you know, it meets the care coordination package, it meets the patient engagement package and it meets this, you know, fictional medication safety package.

They are kind of like, you could see them as plus type of things that would be underneath a regular certificate that was issued as an easy way to communicate the functionalities.

Paul Egerman – Businessman/Software Entrepreneur

Okay, thank you.

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

And this is Mike Lardieri, I have a question. So, two questions actually, one is when you add that last, that third hashmark, who is going to identify the "functionality" for the non-meaningful use providers? How is that going to happen?

And the other question I think is building on what Paul was saying is, how will a provider who needs a complete EHR in order to continue getting their money, how will they know which pieces to buy if it's all in packages? How do they know which ones all fit together to make the complete one?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, maybe I'll take this in reverse. Today under our revised certification policy a provider doesn't need a complete EHR to demonstrate Meaningful Use and so, you know, that's kind of point number one.

The second point would be the packaging; the problem that we were trying to solve with the packaging is an easy way to communicate a set of certification criteria to which a product was certified. I mean, maybe, you know, I should probably continue to try and make that point clear. Is there an easy way to communicate, you know, the certification criteria that are part of a product that's already certified to make it easier for providers potentially to understand what criteria or what capabilities may be represented by that package label?

The other, on the Non-Meaningful Use/Meaningful Use division or distinction, as an EHR technology developer approaches a certification process they would have a choice as to whether or not they would be intending to market their products to either Meaningful Users or providers that operate in settings not eligible to receive incentives and having those two pathways would give them the ability to design their product in a way that's most efficient and so as, you know, that distinction would be reported to ONC and I expect, or, you know, I think we noted that we would expect the certified HIT products list to have a different listing for products that are not certified for the Meaningful Use specific functionality so that there isn't confusion out in the marketplace.

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

Okay, so on the functionality piece, so how do I know the difference if I'm a provider, a Non-Meaningful Use provider, two different vendors, how do I know the difference, they call the functionality the same thing, how do I know what they really do and don't do? I guess that's where I'm confused.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

I'm not sure that anything changes. I mean, the only difference would be that the – between an MU product and a Non-MU product would be the measurement calculation functionality.

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

Okay, okay, okay that's the only difference.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, let's take ePrescribing as an example, you know, if I design a product to get certified for Meaningful Use and get the MU designation for ePrescribing, so I'm just making a module with one capability I would also, as part of our certification program policy be required to support the percentage-based measure calculation for ePrescribing.

If I'm developing this for, you know, LTPAC or behavioral health for those that do ePrescribing, the fact that, you know, they prescribe electronically 38% of the time or however the measurement works could be useful functionality which the vendor could chose to build in, but from a regulatory certification perspective it seemed like an unnecessary burden to have them build in Meaningful Use functionality for measurement just to get their product certified for a setting that might not use that measurement piece.

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

Okay, but everything else is the same, so –

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Correct.

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

They're using the same codes and, okay, okay that makes sense I got it.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, yeah and that's a good point to be clear on, you know, the criteria are the same except for the downstream part of the certification program policy that requires, today, percentage-based Meaningful Use measures to also be part of the products certification.

So, what we'd be doing with the distinction is relieving that regulatory burden for those products that are designed for Non-Meaningful Use settings.

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

Okay, thanks, that's very helpful.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Steve, it's Larry, I just want to jump in with a comment that I think is relevant to the package notion, not that I want to necessarily resurface a lot of the conversation.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Sure.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

But in the existing criteria, particularly in the 2014, the, you know, as compared to the earlier version things got lumped together and the notion was, "Well we're going to lump things because you have to do them all and these are reasonable groupings and we'll have fewer moving parts." But it wound up lumping things together that are not functionally needed for each other and so you could have one type of ordering and not another type of ordering but the lumping certification required that they be tied together.

In another instance you separated content from transport. So, it used to be that there was one criteria for what you send that also included how you send it and those are now being split out. So, we're getting more modules, if you will, in the new – in the proposed rule, but it might make sense to then have a package that says, these might have been a single criteria with many parts and now we're saying they're separate criteria that you can deliver separately but you might chose to bundle them together as a vendor and say "I'm offering this as a grouping."

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, so just to pick up on Larry's point, I think the CPOE proposal is probably the most germane here. Today the 2014 edition certification criterion has all three capabilities in one criterion. So, for medication orders, for laboratory orders and for radiology/imaging orders a product needs to show that it can support all three of those order types all in one shot or else it can't get certified.

What we did is we actually created three separate certification criteria for the 2015 edition proposal to continue where we can to support the overall philosophy that we've had – as you may – I'll finish my thought here and then do my other part.

To continue the overall philosophy that where it makes sense to break a certification criterion or split it into more specific functionalities for the purposes of testing and certification to give flexibility we are attempting to do so. That doesn't mean that a developer can't go forward and get certified to all three of them as they do today it just means that there three separate certification criteria.

The reason for that, as we went through the analysis approach again is that as you look at Meaningful Use Stage 2 there are now, you know, kind of three measures for computerized provider order entry one for medications, which I think got increased in terms of the measurement percentage, and then the other second and third have to do with the specific laboratory orders and then radiology imaging orders and as that breaks down each of those have exclusions because certain scopes of practice, more so on the ambulatory side, may not do enough of those types of orders or it may not be relevant to their scope of practice at all.

And so when you look upstream a little bit you say, well, does it really make sense to require an EHR technology developer that may serve a specific setting or a specific scope of practice to design into his product and include, you know, radiology imaging orders if that type of provider never does those types of orders and that would be a just to get certified type of requirement.

So, that's where we've attempted to do some splitting in the CPOE context to add more flexibility to the regulatory structure. So, I don't Larry, I know I've probably taken up more of my cameo appearance than I intended.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, let's talk about the next couple of slides –

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Sure.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Because I think they serve the context for our response.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Sure, so as indicated in the proposed rule and in the materials that we've put out this really begins our estimation that we would go through kind of an incremental process to updating our certification criteria whereby really what we experienced with this and what everyone experienced with the 2014 edition was a pretty comprehensive overhaul of our certification criteria between the 2011 edition and the 2014 edition. As we move from the 2014 to the 2015 that's where we've seen, you know, a more incremental type of update to some of our certification criteria as well as many that we've left unchanged and that would just carry forward.

And so as we shift, you know, and go through rulemaking potentially and this is, you know, kind of an estimated thing that I was able to put together to kind of give folks a three year roadmap which really is more like a 4-5 year roadmap in terms of when the actual regulatory requirements would come into play, this goes to show both that, you know, we have this 2015 edition NPRM which is the black text, it solicits comments both on the 2015 edition but also serves as a vehicle to get early and advanced public comment into our next rulemaking which would be the 2017 edition and so on and so forth.

So, really using our rulemaking for some purposes from now on, one to focus on the edition that we're currently in the process of regulating and then the other part to get early public comment on future items and so that's where we've got a number of request for comment on potential proposals that we could include in the 2017 edition that we like and have given advanced notice to the industry to give us feedback on. So that's pretty much –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, if you look –

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

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Larry Wolf – Senior Consulting Architect – Kindred Healthcare

If we look at what the Workgroup is doing we are taking the 2014 edition using that as our base and providing comments towards the 2017 edition so heading towards the blue line in your chart and now we have this new piece, the 2015 edition, to I guess spur us on if you will.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Correct.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

This is –

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

If we go to the next slide.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Steve, can I ask a question first?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Sure.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

And the next slide is fine for it, 2015 is optional correct?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah we don't – so the 2015 edition does not raise the baseline for the certified EHR technology definition which is what would be, you know, required for the purposes of Meaningful Use and that's the context in which we've stated that the regulatory requirements here are voluntary. Providers can stay at the 2014 edition level to participate in the EHR Incentive Program and EHR technology developers could, you know, keep focusing on the 2014 edition.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

So, some of what was in the 2015 edition was referred to "bug fixes" if somebody were to certify today – is 2015 an all or nothing or can you basically certify against the original 2014 requirements but in addition use the bug fixes or ultimate clarification at 2015 certification?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, it would be our intent for an EHR technology developer to be able to get certified to some of the 2015 if they so choose. The CHPL, the Certified HIT Products List, as it has in the past, allowed for a combination of 2014 edition and 2015 edition technology to be used to meet the certified EHR technology definition. I think it's our intention to fully support the combinations.

So, if an EHR technology developer sought to get certified for a few things in the 2015 edition they'd be able to do that and their customers would be able to have a, you know, combination of 14 and 15 technology.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Okay and is there a protection on the 2015 such that no other federal program would create a requirement referencing it? Will these interim ones that ONC provides be strictly for the purpose of informing or fixing previous or informing future and that we don't have to worry about other federal programs that might speak to 2015 or then current certification requirements and accidentally roll up into 2015?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, that's a good question, you know, there is – the publication of the edition is something that's within ONC's control. If another federal agency were to go through rulemaking to point to the 2015 edition criteria that would be, you know, their prerogative and an opportunity for which the industry would have the ability to, you know, provide public comment to explain whether or not it would be feasible to step up to the 2015 edition.

There isn't – you know, to your question Carl, a prohibition on any other type of programmatic use. So, it's possible for another agency or even a state to point to the updated certification criteria.

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Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

I think, you know, where it comes to other stakeholders seeking to leverage our certification program we would very much plan to be at the table with them providing subject matter expertise also the same feasibility type comments having experienced now, you know, multiple rounds of this and knowing where we are with the 2014 edition making sure that other potential stakeholders that would seek to leverage future editions understand the potential implementation timeline.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Okay, you'll try to convince them not to do that right that's what you're saying?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well, yeah, I mean, I think you have to be pragmatic about, you know, what – when things can be leveraged and at what time.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Okay.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul, picking up a little bit on Carl's comment. Will this Workgroup, the CA Workgroup, be providing a recommendation or a response to the NPRM?

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, I believe so that that's on – and I think Michelle is on as well, right? So, I mean, I think it's the intention to have both the Policy Committee where applicable and relevant as well as the HIT Standards Committee whom I'm sure you can assume is revving up its engines to comment on this as well.

Paul Egerman – Businessman/Software Entrepreneur

Yeah –

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

Yes –

Paul Egerman – Businessman/Software Entrepreneur

And it would seem to me – I'm sorry, go ahead Michelle.

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

Thanks Paul, I just wanted – the only concern that we have is timing. So comments are due by April 24th I believe it is and for this group you've been focused a lot on LTPAC and behavioral health certification so we want to make sure that we get these recommendations to the Policy Committee and then after they're presented to the Policy Committee there could possibly be changes that need to be made.

So, we're going to prioritize that work and then have this Workgroup weigh in and comment on the NPRM. So, there may not be as much time for this group to weigh in just based upon timing and where we're at with other goals.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

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

But as Steve said the Standards Committee will also be weighing in.

Paul Egerman – Businessman/Software Entrepreneur

Well and the reason I ask is I think the question Mike asked earlier about like how a purchaser would view this. I just think that, you know, it would be helpful to have the discussion and at the last Policy Committee meeting there was a statement to something called the Vendor Taskforce would look at this, but I think it's better performed with this Workgroup.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, Paul, it's Larry, I agree that this should be something we should comment on and we'll see how much time we can squeeze in at the end of March and early April to make this happen in advance of the April policy meeting.

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

And Larry, this is Liz, I just want to do a time check, it's 1:05.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Thanks for reminding me that.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

All right, so I'll really quick. So, this is the last slide it lost a little bit of its graphical feel I think in the translation to the display here, but this was my feeble attempt, and I'll be humble about it, of trying to illustrate in a visual way my sense, I'll take complete ownership of this, of the resource allocation comparisons in relationship to when a regulation gets published and the kind of comprehensive nature of the regulatory requirements.

And so, you know, if we look through our passed two rulemaking cycles for the 2011 edition and the 2012 edition, the 2011 edition was the first time that we issued certification criteria so it was a heavy lift. The second time we issued the 2014 edition so again a significant amount of changes and again it was a heavy lift.

And one could argue with the peak and the valley here of the red line which I was trying to show as the HIT developer response and resource allocation relative to the proximity to the rulemaking and also as we go forward what more incremental rulemaking, and none of this is drawn to scale, so you'll have to forgive me, but what more incremental rulemaking could look like in terms of shrinking the amount of changes that occur between rulemaking cycles and potentially, even though it may be a counterintuitive statement that many will disagree, providing EHR technology developers with more time to focus on the things that they want to focus on besides EHR certification and their own innovative and software development lifecycle agendas and responding to customers.

And that was, in that context, you know, one of the points of feedback that we were trying to address with a more incremental rulemaking that didn't make as many changes but gave an advanced look at what certification criteria requirements could be in the future as well.

So, whether or not you agree with that that's another point of feedback that could equally be provided by this group, but this is my last slide and that just gives you a little bit of a voiceover for what I'm sure is a bit of an inkblot type of slide here unless you hear me talk through it. So, that's it for my prepared ramblings as I like to say.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, thank you Steve, I heard interest from the Workgroup and maybe a strong interest in responding to the NPRM so we'll figure out how to shoehorn some time into our schedules to do that.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Great.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And we probably also need to do a quick review, we'll work with ONC staff on this, of where an NPRM is specifically asking for input on LTPAC and behavioral health. So, thank you, with that let's move onto the next slide.

Steve Posnack, MHS, MS, CISSP – Policy Analyst – Office of the National Coordinator for Health Information Technology

Thanks.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so we're going to be taking a dive into the guts of our recommendations to the Policy Committee. Let's go onto the next slide.

So, this should look familiar from last time we met. The breakouts were the same. There is a minor edit in that on the behavioral health setting where it says “consent management” we’re noting that really the intention is to cover that in the all provider’s enhancements to privacy and security and we’ll be talking with Deven from the Tiger Team actually pretty soon if we’re close to schedule.

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

So, this is Mike, Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes?

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

So, this would then apply to every provider across the board not just behavioral health providers?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That’s correct.

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

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Because the notion is if you set a flag in a document that you’ve sent on that says this can’t be redistributed their system needs to know how to deal with that otherwise the flag is not of much value.

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

Okay, fine, yeah, that makes sense to me.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That’s the notion in that thinking.

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

Gotcha.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, the next several slides are grouped this way, there are red headings, green headings and blue heading slides that walk us through the next level of detail. So, let’s do that.

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

Larry, this is Michelle.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes?

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

I’m just going to ask – I know that Deven is on –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

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

Would it possibly make more sense for us to hear from Deven and then come back to this? I don’t know what –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That would be perfect.

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

Okay, thanks.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Well, so it's Deven, if you want me to react to what you guys are recommending I'm perfectly fine if you want to just continue to go through your slides since you've been having a discussion about this for quite some time. You know it's completely up to you though. You all have considered this issue far more recently than we have on the Tiger Team.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, maybe what we should do is – so let me hit some high points and then I think we can – we'll see if we can go through the next couple of slides quickly because once we get to enhancements to privacy and security is where we would want you to chime in anyway.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, it should be close to the beginning here. So, what we looked at for all providers was our priority coming out of this almost from the beginning was we wanted to enhance information exchange and interoperability as it relates to transition of care and transition of care is the name of the current certification criteria which is why that phrase appears here.

And then related to that, that privacy and security be in place for all providers whether or not they're in the Meaningful Use Program because that was foundational. If you're going to be receiving information you need to be a good steward of that information at least at the level of privacy and security.

And then mostly driven by behavioral health we feel there needs to be some enhancements to what's currently in the privacy and security criteria. So, maybe that's enough intro for now. Are we okay Workgroup with moving on?

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

Yes, I am.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Great, silence is consent. So, how about if I let ONC walk us through this quickly because I think this all stuff we've been through many times.

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

So, I think everything on these two slides are consistent with what's in the Stage 2 Meaningful Use rule. The second on the left-hand column, the one piece, the second bullet there on transitions of care is simply to note we've had a number of discussions on the fact that there are some updates to standards related to ToC and care planning and if those are supported or are approved by HHS for Meaningful Use Stage 3 then the Workgroup would also support it for LTPAC and BH recommendations so that's one edition that's not part of MU2.

The second part on the privacy and security side, the second bullet there, is also in reference to some of the feedback from the LTPAC hearing and it's to state that HHS should support educational awareness initiatives for LTPAC and BH providers including informing these providers that compliance with HIPAA requires actions that extend beyond ONC certified privacy and security criteria.

Again, this is in response to the – I think one vendor's comment around, you know, whether or not certification could – certifying a product would then make that product HIPAA compliant, it may make it so.

Paul Egerman – Businessman/Software Entrepreneur

Could you explain what that means? Because I just don't understand how does HHS support educational awareness initiatives?

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

Well, I think it's just the idea that we would – that HHS would make these providers aware that simply certifying to these criteria does not mean that they are HIPAA compliant that there are other policy components that they would need to follow. So, we just would provide some education around that.

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

Right, hi, and this is Elise Anthony, from ONC, just to echo Liz's point, you know, provider awareness or provider education happens at a number of different levels at ONC at this point as well as at CMS. And at ONC you have the provider adoption support office that focuses on outreach to providers and working with the RECs.

In addition, everything from our website as well as to materials can also help to supplement that if that's what the Workgroup decides they want to do.

Paul Egerman – Businessman/Software Entrepreneur

Okay, thank you.

Joe Heyman, MD – Whittier IPA

This is Joe, you know, I think that this could be – I mean that would have to be carefully done because I think that if behavioral health people are going to be using certified, whatever you want to call them now, modules and privacy and security is somehow certified that these things meet requirements that they are properly encoded and properly – so that you can't – they're not just simple e-mail type things.

It seems to me that it could be very confusing because people need to know that they are HIPAA compatible that they meet the requirements of HIPAA in order to be able to use them. I think it's obvious that people have to do more than just use them to be HIPAA compliant but I think at the same point somehow it needs to be obvious to the purchaser that these are HIPAA compliant. Am I making any sense?

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

Yes, I think we would certainly point out that, you know, that these could be used to support HIPAA.

Joe Heyman, MD – Whittier IPA

Yeah.

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

I think that the point we're trying to make is it's not only this.

Joe Heyman, MD – Whittier IPA

Right, I understand that, I'm just thinking about how you would make that point. I think you wouldn't want to make that point at the expense of people not being sure that these things meet all the requirements that HIPAA has for EMR modules. I guess that's the point I'm trying to make.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well I think, this is Larry, I think that since the driver really starts with organizational policies and procedures and assessment of risk that then you would chose technology that is consistent with those decisions and we're saying that this technology does provide a reasonable base to use but in and of itself it's not and that you could abuse it as well. And so I think that's sort of the line we're trying to walk here of not to oversell this just by having this technology that you're all clear. But to your point, Joe, not to further muddy the waters by getting people anxious about things that they need not be anxious about.

Joe Heyman, MD – Whittier IPA

Yeah, like the word “encryption” was what I was looking for before I couldn’t think of it, but, you know, that’s an example. I mean, people need to know that that satisfies those requirements, that at least the technology part meets the HIPAA requirement. The technology part meets the technology part of HIPAA requirements.

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

Yes.

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

Right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I think you’re talking to the challenge of the education.

Joe Heyman, MD – Whittier IPA

Exactly and not to make it confusing. I’m worried that trying to educate will make that portion of this confusing and people will not understand that, yes they are meeting the requirements for encryption and that kind of stuff, the technological requirements are using this stuff.

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

Yeah.

Joe Heyman, MD – Whittier IPA

But on the other hand there are other things that they have to do in addition and I’m worried that trying to tell them that is going to be confusing.

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

Would it make sense to –

Joe Heyman, MD – Whittier IPA

But I will leave that to the brilliance of HHS.

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

This is Mike Lardieri I’m just wondering if it makes sense within this section if you just add an extra piece there that says, you also need to conduct your HIPAA security risk analysis as well. I’m not sure, but I think that’s the message you want to get to people.

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

Yeah, that would be part of the educational materials.

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

So, this is Jennie, and I have a question, comment on the transition of care second bullet on the left where it says, if in addition, if approved by HHS for MU3 support inclusion of emerging ToC and care plan standards being reconciled as part of the Consolidated CDA and then the bracket MU Workgroup identified MU3 criteria.

Well, we just heard from Steve about this NPRM for the 2015 edition which advances MU and Non-MU certified modules and I’m wondering if this bulleted recommendation here should be “just if approved by HHS.” Because we’re talking here about long-term post-acute care and behavioral health providers and, you know, they are not part of the EHR Incentive Program.

And so I think with the 2015 edition there is this path forward to unbundle, you know, separate out the Meaningful Use certification from Non-Meaningful Use.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, Jennie, I think that's a really good point and I think probably in general we've been using MU3 as a co-shorthand for 2017 edition and now we've got 2015 edition to worry about. So, I think your thought of more broadly stating this as part of HHS or perhaps more focused as certification criteria and really our recommendations are all around certification criteria not around Meaningful Use and so wherever we've got MU in here we probably should think about if it can be re-phrased as certification criteria without referencing MU.

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

Thank you.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, this is Paul, this is Paul, I'm not so sure about that. I just have a feeling that it's important that this program somehow continues to be correlated with the Meaningful Use Program because there are a lot of vendors who provide software to both sides and it would in my mind be a mistake if you let, you know, LTPAC get ahead of Meaningful Use at any stage.

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

Well, and this is Elise Anthony, I will say that the deck as it's constructed as you go through there are a number of references to the actual MU language already in place and that might obviate some of the concern there because it does have a direct correlation to the existing MU language. Even if that should change to Non – to MU and Non-MU construction for references on the CHPL you'd still have the references that are included here to the 170 sections. So, that might address some of that concern.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and the point I'm trying to make is I guess I'm saying I like it the way it is and I also don't think we should necessarily assume that what's in the NPRM will end up in a final rule. I think that I trust ONC will respond to whatever public comments they get and I can't predict what those public comments will be but we don't necessarily know what the final rule will be. So, I think we should sort of like stay the course and leave the references to MU3 there exactly as it is.

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

Yeah and so this is Jennie and I think I disagree with you because, you know, through our conversations over the last couple of months or whatever we've made note about wanting to leverage MU2 requirements when applicable, when appropriate and so transition of care I think is a very good example of that.

And so, as I'm sure everybody knows, and as reflected in the 2015 NPRM, which who knows how that will play out in terms of final rulemaking, but that NPRM solicits comments on using the emerging Consolidated CDA, you know, that's undergoing reconciliation.

And so I don't see why it would be problematic to – if the final rule, the 2015 final rule goes forward and embraces the emerging Consolidated CDA why we would want to limit long-term post-acute care and behavioral health vendors developing Non-MU certified products that incorporated the emerging Consolidated CDA.

Paul Egerman – Businessman/Software Entrepreneur

And I guess my response to that would be the transitions of care occur between the eligible providers and the non-eligible providers and if you've got acute care hospitals using the 2014 version that's really not going to be the same version that the extended care facilities use. This seems to be creating an odd mismatch.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

I agree and as a vendor person who actually has one single integrated system that does both care delivery as well as the long-term PAC side of care delivery I have to look at this as one system trying to meet both sets of specs at the very same time and I agree I think it should be – it should track with what's actually required for Meaningful Use especially with regard to interoperability because that in part, in a significant part, is the point of doing this right?

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

And this is Mike, yeah, I think you need to keep them in sync and I don't see how it works unless you do keep them in sync.

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

I don't know what sort of backwards compatibility there would be with the emerging Consolidated CDA. It just seems – I know a lot of – or some of the changes in the Consolidated CDA have emerged because of provider and vendor interest in advancing enhancements to that standard to support care giving in long-term post-acute care and behavioral health sectors. And I don't understand why it is necessary to slow down the voluntary adoption and implementation of those enhanced standards.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, to respond just to that, first is certification does not stop somebody from advancing. I mean, if somebody wants to do something new they can do it and they can certainly do it easily in the whole LTPAC space that is not eligible for Meaningful Use, they don't need to be certified to do it. So, I don't see how certification or lack of certification slows anything down in that space.

My second comment is as I'm listening to what you're saying about 2015 and we really want to jump on it and start to get, you know, LTPAC people to using the latest and greatest and I actually view that as an argument against the NPRM that is being proposed by ONC, you know, it goes back to Carl's comment, you put forward this 2015 edition and now other regulatory functions are starting to refer to that and that's going to create a huge, huge potential problem in terms of confusion in the marketplace but also in terms of getting these systems to interoperate to work with each other.

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

Yeah, this is Mike, I think this is a tough one because I'm with you Jennie, I don't want to hold anyone back, but if they go too far forward then what they send nobody else will be able to read until everybody else catches up and I think the most important part is being able to send and receive, and share. You may have extra pieces but maybe we can't get them there fast enough until everybody else catches up.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Hi, this is Larry, let's not get hung up on sort of good and better chasing each other. We do have these backwards compatibility issues, not everybody is going to be upgrading at the same moment even if that's what was required, you know, in terms of the editions. So, I think we should acknowledge that there is going to be a timeline of adoption here around this and particularly to the point that the 15 edition is going to be completely voluntary.

But, I think, you know, the whole point of having the more frequent editions was that so ONC could point to newer standards and say this is the newer standard that we're moving to and you have transition time. So, I guess I'm going to ask that we don't –

Paul Egerman – Businessman/Software Entrepreneur

So, where do we stand on this? In other words I'm advocating for leaving this as it is and keep it in sync with MU3. I'm also advocating for saying the 2015 thing is a proposal and we shouldn't be trying to adjust to something that's being proposed until it's final.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

I would be –

Paul Egerman – Businessman/Software Entrepreneur

And some people are saying, no let's go ahead and assume that it's going to happen and we want to make sure we get the latest and greatest for LTPAC. So, how do we resolve this?

Carl D. Dvorak – Chief Operating Officer – Epic Systems

And this – you know, pushing it forward here maybe the thing that kills it because it's either optional or it's not. If it turns out that every one of these incremental certifications is going to be used by some other program as a requirement then pretty soon they're not really optional in the first place.

So, I think we should strongly recommend that with regard to LTPAC the interoperability tracks with the 2014 or the 2017 but not an interim in the middle. If people want to use the interim as informational to plan their development for the future like it was spoken to be, fine, but I think if we're trying to cross the bridge of interoperability between hospitals and physicians, and long-term and post-acute care settings we really should strongly recommend a track to 2014 and 2017 and treat the interim update as informational.

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

So, do we have consensus on that point?

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

Not with Jennie, but I seem to be the odd person out on this one.

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

Can we –

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

Yeah, this is Mike, I just don't know how to – you know, you do the backwards compatibility, I agree with what was just said because unless you do that, and from the behavioral health side, unless you do that I'm a behavioral health provider I'm not going to be able to send to anybody, I'm not going to be able to coordinate care if I'm too far ahead and there is no backwards compatibility unless there is and we know that for sure then I struggle with it and I think we have to keep them in sync.

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

Yeah, well, so, but we know the Consolidated CDA is both structured and unstructured information and so if you're dealing with a system that can't receive it then they can at least receive the text.

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

Well, if it fits within that – if it could fit within that way then I think that's fine, but the bottom line is it has to meet 2014 and then be in sync with 2017 and if you can do these adjustments and it fits within the text in the meantime, yeah, I think that works, that makes sense.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

And Jennie, isn't that also true in the 2014 Consolidated CDA?

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

Yeah, but the thing is, is that, you know, I know we don't want to spend all day on this one point but just as an example, in the care plan, enhance care plan section of the Consolidated CDA additional data elements and sections would be included in the enhanced Consolidated CDA.

If a long-term post-acute care vendor was using a product that incorporated the enhanced Consolidated CDA and wanted to transmit a care plan to an acute care hospital that acute care hospital could receive part of it in structured format consistent with what's in the 2014 edition but they could receive the rest of it, the text document consistent with the refined, you know, the enhanced Consolidated CDA.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Yeah, I think –

Paul Egerman – Businessman/Software Entrepreneur

The enhanced C-CDA that's being proposed in an NPRM that has not been finalized yet.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Yeah. Jennie, I think it's always reasonable for people to work ahead if they chose to or have the business case to, but I think as we consider this as guidance for certification I still strongly think you'd want to certify a matching standard so that a buyer could have some assurance that plug-and-play they knew what they were getting and they knew how it would work. I just don't see value in LTPAC really being able to communicate only among LTPAC providers on a different standard. I think –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, this is –

Carl D. Dvorak – Chief Operating Officer – Epic Systems

Go ahead, Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, these I think are all really good points that maybe we can work with ONC and see if we can get a couple of very specific references here as sort of our first dive into this and also that it winds up in our general principles of really building on the existing certification criteria and not creating a new walled garden that separates one group of providers from the others, that the point here is to be able to exchange information.

And that I think we need to acknowledge as feedback to ONC about these interim editions that while in the end they may create clarity about how these are steps along the way, at least at this juncture, they are potentially adding to confusion about intermediate versions that may create backwards compatibility issues with established certification criteria in systems that meet that criteria.

So, does that capture the sense here? That this is really about being aligned, about building on what's already been in rules but also acknowledging that that's going to change over time and that here is a particular driver, some standards that were built to address a need in a setting but they are only successful if they are broadly applicable and not just in the setting.

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

And also Larry not wanting to unnecessarily or inappropriately slow product development down. You know I think there are vendors both in the acute care space and post-acute care setting that are looking and are developing products to meet the new Consolidated CDA. So, I just – I think including that concept as well is important.

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

Yeah and this is Mike and I think you have to spend a lot more time on this then you're going to have the whole – I think to me this is like the most important thing of all of what we're doing and if we don't do this right then the rest of it really doesn't matter. So, I think even if we spent extra time on this at some other point that makes good sense.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so we have some marching orders to try and clear this up for next time because I think, as Mike points out, this is the make it or break it and the concepts we've been talking about equally are make it or break it of how to understand what we're proposing in the context of the existing programs.

So, having said that I think we're – I think we're ready to go onto the next slide that talks about enhancements to privacy and security. So, let me give a tiny bit of context, it's not on the slide, so that Deven knows where we are, I want to make sure we haven't lost you Deven, are you still there?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

I am.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Great. So, this slide very quickly dives into, you know, a specific HL7 classification system but the context in which this arose was some of the specific requirements related to substance abuse programs that have very particular consent requirements and re-disclosure limitations on information that is sent and in general our understanding is that very few of those providers are contributing data to any kind of health information exchange and that any existing broad-based health information exchange as a community, you know, health information exchange organization, in general has been saying, if you have any information that needs these extended restrictions don't send it to the exchange because we don't know how to enforce them, anything you send we're going to assume we can freely, not freely, but we can distribute under the general consent rules not the SAMHSA enhanced consent rules.

And so that led to the discussion of, so where is that currently and in order for those technologies to be viable they can't just be viable in the context of behavioral health there are things that actually would apply to all providers. So, I think that's the context for this slide. Is that enough for you to jump in with where the Tiger Team is on this?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

So, let me just ask a quick question Larry. Is what you're recommending that the Tiger Team in fact take a look at what you all are proposing or are you –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Okay. So, we'd be of course happy to do that. I will just fill you in on a little bit of background the last time we looked at this issue which I think Paul Egerman will probably remember fairly well because he was my co-chair when we did all this work back in the summer of 2010.

Paul Egerman – Businessman/Software Entrepreneur

Many fond memories Deven.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

That was so much fun. We essentially took on the issue of consent more broadly but recognized that there already was as a policy matter at both the federal level with respect to the 42 CFR Part 2 rules, which you all are now familiar with, as well as with respect to a number of state laws, there already were policies in place that targeted particular types of data for enhanced protections typically in the form of additional consent requirements before that data could be shared.

And the 42 CFR requirements of course include that the protections requiring consent essentially travel with the data. So, anyone who subsequently receives that information needs to know that in order to re-disclose it they would need the consent of the patient that may be characteristic of some state laws, I'm not the state law expert, I can't tell you for sure which ones have that capability, but we certainly know that the federal law does.

So, at the time what the Tiger Team did was sort of take this on not as a policy question, i.e., should you or shouldn't you because the policy was already in place, but instead to inquire whether we had the technical capacity for providers to honor those consents when they were required.

And we had a large hearing on the technical capabilities that were available at the time and the letter goes into some detail about some of what we found largely a lack of maturity, at that time, so remember this was 2010, among the technical capabilities that were available in order to assist providers in honoring these consents, although at the time the technology that seemed to be the furthest along was one that would not attempt to segment at the granularity of a particular data field for example, but instead be, you know, cover an entire document or an entire encounter.

But nevertheless, what we recommended at the time was that the technology was promising but still in very early stages and that there would need to be pilot testing because ultimately what would be needed is not a speculative or theoretical approach to addressing this issue but one that had been actually demonstrated to be workable.

But we also made the point that patient education here was going to be fairly important because even in circumstances when you can apply a flag for example or restrict the disclosure of a certain document or a certain specific type of data that there would likely be inferential information that might allow people to put two and two together or what some members of the Tiger Team refer to as data leakage, i.e., you know, maybe the data that is desired to be protected is shielded or filtered, or segmented, or sequestered whatever term you want to use in one particular document but then it shows up in another record where that filtering was not applied like in notes for example.

And so any time you use these technologies it would be important, even if the technologies got improved and got into more widespread use, that patients be made aware of what any potential limitations would be to those technologies.

And so, since that time we are of course aware of the work that has been done by the S&I Framework on this issue, although I think you all are probably more up-to-date on how the pilots have gone, we have not yet had an opportunity to be briefed on the results of them.

We have put off any further attempts to reassess our recommendations until we get a more full report on where the technology is and it sounds to me like that's – we are now in the place where it's time to review that technology and take a look at it and reassess our recommendations on that point.

So, I guess the bottom line is that we saw some promising approaches but we didn't think they were ready for primetime back in 2010. We acknowledged that with any given approach there would probably be pluses and minuses and that that type of information would need to be communicated both to patients and providers using the technologies, but that ultimately this was a priority and it was important to make some progress in this area.

And Paul I don't – let me know if you think I've left anything out that's essential?

Paul Egerman – Businessman/Software Entrepreneur

No, I think you did, as usual a really excellent summary Deven. You know the only observation I'd make is this group is under a time constraint of making a recommendation on March 11th at our next Policy Committee meeting –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Well –

Paul Egerman – Businessman/Software Entrepreneur

Roughly in one month and so the question is, are we at a point where there have been enough pilots, we know enough about it, there has been enough testing that we can go in front of the Policy Committee and say “yes, this is ready for primetime.”

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

Paul, I think the recommendation can simply state though that this has been turned over to the Policy – to the Tiger Team to look at, I mean, for March and then after discussion has been had on the Tiger Team that recommendation can be brought forth to the Policy Committee. So, it doesn't have to happen on March 11th is what I'm saying.

Paul Egerman – Businessman/Software Entrepreneur

So, can we make that same thing for other parts of our recommendations, can we push a lot of the other ones forward too if we're not quite ready? I'm just curious or is it just this one that we're allowed to do that?

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

Well, so the quality measures one is a similar situation where it's also gone over to the Quality Measures Workgroup, right? So, the recommendation is that this other group that's been focused on it have a discussion.

Paul Egerman – Businessman/Software Entrepreneur

Okay, well, so, okay, so I guess in that response there is an answer, we agree that this ain't ready for primetime as of March 11th that there has to be some additional something that goes on here, some evaluation or something. Is that fair, Deven?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Well, you know, I think that's probably one way to approach it although you all have been having discussions on this issue for quite some time and, you know, based on the previous slide that I saw in terms of sort of wanting to recommend that the EHRs for LTPAC as well as for other providers have capacity to be able to accommodate compliance with these rules. I mean, that's a significant step in a similar direction, but if you really –

Paul Egerman – Businessman/Software Entrepreneur

Well –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

But if you do want the Tiger Team to be able to review this in full then it is absolutely correct that it will not be done before March 11th.

Paul Egerman – Businessman/Software Entrepreneur

And compliance was the rule is a big deal is the way I'm looking at it, maybe somebody can correct me if I'm wrong. So, you have this re-disclosure concept and so re-disclosure is not permitted for somebody from a federally support of substance abuse, a treatment center who happens to be, for example, an acute care hospital, but if you then want to transfer that patient to an extended care facility and re-disclosure is not permitted you'd have to have a system then that won't produce a transition of care document even though the extended care facility won't take the patient without that document and so I don't quite get how it's all going to work but maybe somebody can tell me if I'm looking at it wrong.

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

Or have a flag in there that will tell you to get a consent so you can send it. I mean, you –

Paul Egerman – Businessman/Software Entrepreneur

Well, but at that point in time my view is, again this is perhaps a policy issue that Deven's team has to look at, is aren't you coercing consent? In other words if you have a patient who is in a hospital and we say "unless you give consent we're not going to put you over to this extended care facility." The patient says "well, what's going to happen to me?" And the answer is "well, you can't stay at the hospital any longer because, you know, we don't have any beds so I guess you'll be out on the street." And the person says "well, I guess I have to do a consent." I mean, that sounds coercive.

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

Well, I mean, you could do that with everybody, well that's not the way to do consent. I mean, you can say that when you're referring from one place to the other if you presented consent that way "that I'm not going to refer you unless you give this consent." I mean, that's – we don't do consents that way, but that could happen at every step of coordinated care with substance use it's not just that one instance it's any time along the way. And what we have to do is –

Paul Egerman – Businessman/Software Entrepreneur

Well, I agree, I think it's a problem with the process.

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

Yeah, okay.

Joe Heyman, MD – Whittier IPA

This is Joe, I just want to say in a real world context with a health information exchange any patient that releases sensitive information to the health information exchange that information is available to others no matter what and in the consent process, at least in our consent process, we actually have the patient initial for each piece of sensitive information, so whether it's drug abuse or reproductive health, or mental health, or whatever we've got those little check boxes that they actually have to initial.

And then on top of that we have some software ability to ask people if they're going to look at some sensitive information to warn them that they are looking at sensitive information and that they need to have a reason to do so. So, it's like a two-step process to look at that.

But, we know that even that software can't filter out every bit of sensitive information for all the reasons that were mentioned earlier and therefore there is – I mean, I don't think technologically there is a way to prevent some of that information being seen by a third-party and having that happen because the person is on a health information exchange.

So, we tell patients that if they don't want any of their sensitive information to be seen by anyone else they shouldn't join the health information exchange period.

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

Yes and the work –

Joe Heyman, MD – Whittier IPA

For whatever that's worth.

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

No, this is Mike, and, you know, the work that I do with five state HIEs many of the states that didn't have the capability, only one state did, to segment the data that way that's exactly where they landed is to let people know not to share information in the exchange.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I guess we're looking at a couple of things, so to refocus this one, we're asking of the Tiger Team. So, we've heard for example that there are some new HL7, relatively new HL7 standards around this that there has been at least some implementation in available software from one vendor, from Cerner, around this particular thing. We don't know where other vendors are. We don't know – we don't have – I don't say we did any kind of dive into a vendor assessment of easy, hard, soon, later their input into whether this should be 2017 edition or not.

So, there is more work to be done around this particular thing and my sense, in terms of the Workgroup's charge, to focus on LTPAC and behavioral health that what we were doing here is raising this up a level and saying "this is important if you're going to include these providers this needs to be addressed for all providers."

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think that's where I sense the direction we're heading in.

Paul Egerman – Businessman/Software Entrepreneur

That part, yeah, I agree. I mean, it doesn't make sense to just do it for behavioral health whatever we do has to be done for all providers.

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

And I guess the only thing I'd add to your summary, Larry, it's a hard problem.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It is a hard problem.

Paul Egerman – Businessman/Software Entrepreneur

It seems like a dumb thing to say but that's – I mean, everybody wants to do the right thing but no one has a really good solution yet, although maybe some are emerging.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

What I do want us to talk about –

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

And this is –

Carl D. Dvorak – Chief Operating Officer – Epic Systems

This is Carl, one second Mike while I jump in. What I do worry about is that in its trivial form it's easy to do and NCVHS did a study a long time ago that said "well, when data is authored it is put into six discrete buckets then it's easy to block off one of the discrete buckets from going anywhere" but that's not actually how caregivers document and order, and comment, and interact.

And that the real puzzle isn't the trivial form. The real puzzle is how do you solve it in its practical form and I want to be careful that we don't put forward a solution in a trivial form and presume that conquers it in its practical form because this one is important to get right and it's important for patients and their expectations, and it's also important for patient safety.

So, I think although many of us have done things like this for years and years, and years to have sensitive tests and HIV testing and things like that in its trivial form it's easy, in a practical form it's going to take a lot of thought.

Joe Heyman, MD – Whittier IPA

And I guess, this is Joe again, I guess the point I was trying to make was in the real world there really isn't a way to accomplish what the law requires. I guess that's what I'm trying to say unless the patient refuses to share the information.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

I agree.

Joe Heyman, MD – Whittier IPA

At least when they are on a health information exchange.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Although we had testimony Joe, this is Deven, from Rhode Island when we had a hearing on query response types of health information exchange and they in fact are exchanging behavioral health data and essentially there is this sort of double consent process associated with it, but it's document-based.

Joe Heyman, MD – Whittier IPA

Yeah, but that's a whole document. On a health information exchange information that comes from extraction methodology gets up on the health information exchange in the form of progress notes, also the drugs are there, I mean, there is so much stuff that is related to sensitive information that I would venture to guess that even that – the people in Rhode Island there is some sensitive information that gets by.

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

And –

Joe Heyman, MD – Whittier IPA

I just think it's impossible to absolutely prevent it.

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

Yeah, this is Mike, this is – Rhode Island was one of the states we worked with and the way they structured their HIE from the beginning was built to support opt in but you're right it still is all or nothing. So once a patient opts in, client/patient/consumer, once they opt in everything goes.

There is no way to segment any pieces of the data and the patient either decides they want in and Rhode Island is able identify or they have a process where the patient can say "just send to this provider, just send to these two providers or you can send to all my providers involved in my care."

Most of the other HIEs that we spoke to they didn't build their HIEs that way and for them to build the HIE and bounce off or calculate the day the person signed the consent versus the date a future provider joins the HIE they can't do that and the estimates that we got from each HIE was around \$500,000 to \$750,000 each to reprogram their systems across the HIE in order to do it, so with the 200 and so HIEs across the country that may not happen.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, guys –

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

What is recommended –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

This is great input to the Tiger Team.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Oh, thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

But I think we've demonstrated to them where this is a touch issue is both a technology piece and more than just technology here.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So – and I agree we're not going to have an answer by March 11th either.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Okay. Well, we knew this one was coming back to us some day and it sounds like you all are tossing it right over the transom.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes we are. Thank you.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Any help we can be as you move forward I'd be glad to contribute.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Well, I think it's already important that you all are making the statement that the standards should, you know, essentially be, you know, the ones for behavioral health should also be ones for provider EHRs so we have to keep that in mind. Whatever sort of policy we come up in this space has to work across the board not just for one set of healthcare providers.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's the main point.

Joe Heyman, MD – Whittier IPA

And I guess, this is Joe again, I think it's really important to keep in mind that we're going beyond EMRs now and we're going to health information exchanges and as a matter of fact the fact that you're doing a modular approach means that there may be applications that just sit on top of health information exchanges for record keeping rather than just the conventional idea of an EMR in the future.

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

That's a good point.

Joe Heyman, MD – Whittier IPA

So, I think you need to think about the fact that it's always shared information now. It isn't information that can – I mean, five years from now if everybody is on an HIE everything is being shared.

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

This is Jennie, just a technical comment on the last bullet on the slide. Consent management functionality needed by BH providers should it be limited to just BH or just needed by providers?

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

It can be needed by providers Jennie.

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

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And maybe we can even – give the other comments, Joe's comments, it could even be organizations.

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

I'm going to do a time check I think it's time to move on.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It's way over time to move on, thank you.

Carl D. Dvorak – Chief Operating Officer – Epic Systems

And I apologize I have to drop off early today, sorry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, let's move onto the next slide. So, this is beginning to now get into the specifics for LTPAC and there are a couple – one slide, I guess the specifics on behavioral health and a bunch of general ones. So, we're proposing some new things here that are not currently in certification criteria that supports some required capabilities in these settings. Liz you want to give us the highlights?

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

Yeah, so basically these three criteria, the first one is around the ability to create, maintain and transmit the patient assessments and data sets in a way that's consistent with CMS requirements and so the specific patient assessments are listed there and in parenthesis is the setting that they apply to.

The second criteria is around the support of accepted vocabulary standards for clinical purposes and administrative purposes.

And the third one is to support the ability of the provider or designated third-party to create and exchange interoperable LTPAC assessment summary documents. And then there would also be a recommendation to the Standards Committee to exam the availability and readiness of vocabulary standards, this would be to support the second bullet for patient assessments and LTPAC assessment summary documents which is the third bullet.

And then there would be some future work around harmonization of federal content and format for patient assessments with ONC specified EHR standards and making a data element library publically available and linking the contents to nationally accepted standards.

Paul Eggerman – Businessman/Software Entrepreneur

So, this is Paul, I mean, I just have a couple of questions. Is this brand new? In other words, I don't remember seeing this, is this brand new or did I miss something?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

This came up during our discussions of LTPAC that they do have specific assessments and we did talk about that.

Paul Eggerman – Businessman/Software Entrepreneur

But this screen itself is new?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

This screen, so we've reformatted the screens over the last several weeks. So, the content here should have been in earlier things that we've seen.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

And it says you want us to support the ability to create, maintain and transmit information to CMS.

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

These are things –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

These are things currently required.

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Pardon me?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Go ahead Liz.

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

I was going to say this is in accordance with what CMS already federally requires. So this is what is currently federally required.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So any questions or comments about this one or are we okay?

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

This is Jennie, I agree with this recommendation, it is what we talked about before and it supports a big business case, clinical practice in across these long-term post-acute care settings.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And it's also something that the vendors are currently doing, the top one, right?

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

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's already in place today.

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

Correct.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And what we're – the things that are new are there has been some work done on aligning vocabulary but this is trying to move it ahead and the same thing on the CDA versions of these documents is that right?

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

Yes.

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

Correct.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, we have examples of this in actual use, actually I know a lot has been done with the work that was started at Keystone HIE and developed at Geisinger and I know at least three or four places that are using their conversion tools to create those CDA documents. Hearing no discussion let's move on. Next slide, please.

Okay, so now moving to the behavioral health assessments where we heard a very different story that there is a huge variability here and so we're really recommending some future work and some directions. Liz any highlights here you want to mention or Elise or whoever is taking behavioral health?

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

Jen, do you have anything else to add? I think the point here is that we had mentioned on the last call that there is really a need for identification of vocabulary standards and data definitions to support the assessment. So, this would be something for the Standards Committee.

Paul Egerman – Businessman/Software Entrepreneur

Yes.

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

So, I guess I don't see that on this screen, but I think that would be important. I don't understand the ability to provide surveyors, who are these surveyors with complete access of complete EHR? Who are these surveyors that you are giving complete access to?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, there's a bullet, there's a slide that we were looking to get further input from CMS on, but on the LTPAC side there is federally mandated – well, there is a state survey process that has federal guidelines.

Paul Egerman – Businessman/Software Entrepreneur

This is for BH right now?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

No.

Paul Egerman – Businessman/Software Entrepreneur

Oh, I'm sorry this is LTPAC, okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

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

We're on a different slide at this point, they went at a different order relative to what was sent out.

Paul Egerman – Businessman/Software Entrepreneur

So, we're on the behavioral health side, right?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Okay, sorry, I got confused.

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

Yeah, well –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Go ahead Liz.

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

I was just going to say that slide that you were looking at Paul we're going to come back to it on the next call because CMS is going to provide additional –

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I was on –

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

Additional input.

Paul Egerman – Businessman/Software Entrepreneur

I apologize I was on the wrong slide.

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

Yeah, yeah.

Paul Egerman – Businessman/Software Entrepreneur

So, this is fine.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, let's go onto the next slide. So, this was really meant to be an introduction to the next grouping. We've introduced the notion of some providers. So, the question is, does this appropriately capture why we've said "some" and the focus here was that there is variability among the LTPAC and behavioral health providers.

So, there isn't a single one-size-fits-all. Some of the criteria seemed to apply more strongly in some of the settings than others and by using a modular approach people could pick and choose the pieces that made sense to them, but that the ones that are going to follow all seem to sort of jump above a minimum bar of being of value in the settings.

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

It sounds good to me.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, everybody is stumped that's good, let's move on because we have 20 minutes to get through 20 slides or something, we'll pick up the rest on Thursday. Next slide. Okay, so now we're beginning to dive into the next dozen or so groupings. Do you want to take them Liz?

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

Yeah, so the clinical reconciliation criteria is the same as the one that's identified in MU2. In the clinical health information category there is also the first bullet is also all straight from MU2 so the ability to record change and access the data listed there.

The second bullet it about the ability to use electronic notes and the third bullet is around patient lists. And then the one that's new, the fourth bullet, is around considering including the DSM-5 vocabulary standards in certification for all providers. Most of this obviously is consistent with MU2.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul, I guess I'm fine with that except for the new bullet on the DSM-5 I know that's what behavioral health uses, but everybody else is using SNOMED and somehow adding a new vocabulary seems like a backward step.

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

So, the clarification that would be needed is this would be something that all providers – so, I think the feedback from the transcript was that this would be something the Workgroup would be recommending for MU providers as well as Non-MU providers.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I guess what I'm hearing from Paul is the question of are we better off to recommend harmonizing DSM-5 with SNOMED?

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

Oh.

Paul Eggerman – Businessman/Software Entrepreneur

I mean, basically my –

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

I don't know.

Paul Eggerman – Businessman/Software Entrepreneur

My view is ONC does a great job when it says "everybody get on board this is the vocabulary." It's LOINC for lab, it's SNOMED for problems, this is what we're going to do and I think we all need to get on board with that.

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

But –

Paul Eggerman – Businessman/Software Entrepreneur

That I think helps us immensely in terms of interoperability and we need to bring the DSM guys onto that train.

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

Yeah, this is Mike, and maybe I'm just a little off but with the DSM-5 it's not just the problem but part of the DSM-5 it gives you the decision tree for actually coming up with the diagnosis which I don't think SNOMED gives you the decision tree it just tells you what the problem is.

I agree if we could bring the DSM, the APA in and have them do the crosswalk and the decision tree so it means the same that would make sense, but I'm not sure that it works that way. Because it's more than just the problem, it's how you get to the diagnosis is what the DSM-5 book actually gets you to.

Paul Eggerman – Businessman/Software Entrepreneur

And that's interesting because I actually had the same discussion when I was complaining about SNOMED versus ICD-10 and the comment was "well, SNOMED helps you get to the problem a lot faster and it's easier for a physician to use." So, I guess the DSM people think theirs is either tailored better for behavioral health or it's even better in some ways for that. I mean, I don't know, I've never used either one of them. So, I don't know.

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

Well, I know for the DSM-5, I mean I used to – I'd pull it out and you go through the, this for this one, this for this one, has this symptom for this one, okay that's what the diagnosis is and, you know, it provides the whole decision tree for identifying what the diagnosis is at a pretty granular level.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, more than just a code set is at work?

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

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I think our conversation really focused on the code set aspects of DSM not the decision tree aspects and that the desire to get DSM-5 out to everybody was around clearly communicating at the code set level the diagnosis.

So, maybe in fact it should be about harmonizing the DSM-5 code set with SNOMED and that the decision logic piece is an important piece not to lose but is not, is really in some ways outside the scope of the vocabulary. Am I over simplifying here guys?

Paul Egerman – Businessman/Software Entrepreneur

No, I think that's exactly right. Because if what we're going to say is behavioral health should not be like out in left field it should be part of the rest of the healthcare system and we ought to be using the same diagnostic coding processes.

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

I would suggest we pull in people from the American Psychiatric Association who do the DSM-5 and then have them see if what we're suggesting can be done or not, or maybe that's what the Policy Committee would have to do is pull them in and have them discuss it.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Or raise that with standards.

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

Okay or standards.

Paul Egerman – Businessman/Software Entrepreneur

Or something.

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

Yes, but it needs to be done because otherwise behavioral health will be left out one way or the other.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I'm hearing we should split this bullet. We should address the code set piece here and that we should point out that DSM comes with decision logic as well as a code structure and that this should be assessed as part of assessing and implementing the code set.

Paul Egerman – Businessman/Software Entrepreneur

Yeah with a goal of trying to get the behavioral health be able to use the same code set that everybody else is using.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah.

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

Yes I agree.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

We should sort out the mapping –

Paul Egerman – Businessman/Software Entrepreneur

I mean, I want to clearly articulate that's our intention to try to do that. Then I'm very comfortable with this, but I just think actually that would be also something very important I think ONC could be doing as part of this process.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I guess what I'm hearing is another principle about harmonized, fewer and harmonized code sets are better than more and diverse code sets just like standards in general and this is an example of there is one in use in this area that's very critical to the area and needs to be integrated with the rest of the world.

Paul Egerman – Businessman/Software Entrepreneur

Sure, I mean, you want to talk about transitions of care, interoperability, clinical decision support if we've got everybody using the same code sets all those things would be easier.

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

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, good clarification here. Let's move onto the next one. Take it away Liz.

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

Yes, so on the left-hand side we have all the criteria that are relevant to labs and imaging. So, the first bullet really is around incorporating or receiving, incorporating, displaying clinical lab tests and values – the second one is one about inpatient setting have the ability to generate – have the ability to generate lab tests and transmitting them to ambulatory provider EHR systems, it's also in MU2.

And then the three bullets you see that are new are basically making one of the previous criterion on MU2 into discrete criteria so splitting them up. There is a lot of discussion around burden and cost related to requiring – certification requirement around access to the images themselves and that a lot of providers need access to the results information but having access to images themselves is really costly and can be burdensome. So, these three criteria basically split that one criteria up.

And then moving to the middle column these are all the medication related criteria that we discussed so the first one is around transmitting prescriptions and ePrescribing, the second bullet is around drug formulary, the third one is around drug-drug and drug-allergy interactions, and the fourth one is the electronic medication administration record.

And then finally on the last column there is around CPOE, so the ability to electronically record, change and access, so this is also following the order types, medications, labs and radiology. So, again, consistent with MU2.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul I have a few questions.

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

Yes, go ahead.

Paul Egerman – Businessman/Software Entrepreneur

So, these three new bullets, the ability to electronically receive and incorporate narrative interpretations you're talking about radiology is that right?

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

Yeah, so this is all related to images and if you'll recall that these three were in one criteria in MU2.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So –

Paul Egerman – Businessman/Software Entrepreneur

Okay so, that already exists right? There is an –

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

There is an interface for that one. So, you just don't have the reference for it but that already exists?

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

Yeah, yeah I can add the rest on.

Paul Egerman – Businessman/Software Entrepreneur

The ability to –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And actually all of these exist within that right?

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Well, the second one, the ability to indicate to a user the availability of patient's images, where is that?

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

It's in the same criteria it's just all bundled together in one criteria in MU2.

Paul Egerman – Businessman/Software Entrepreneur

It is in MU2?

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

Yeah, these three are all MU2 but it's in one criteria.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

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

So, all this does is split it out.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So we were trying to go more modular here and say – and maybe the appropriate thing here is this actually is a footnote back to all providers that we're saying, we're recommending that the MU criteria, the certification criteria in general be split to separate these three aspects, that you can get a narrative report without the image, you can get an indicator of how to get to the image and then you can actually get to the image and that those are all separable.

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

Yeah and just FYI the regulatory citation for the availability provision is §170.314(a)(12).

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

Yes, I'll add it.

Paul Egerman – Businessman/Software Entrepreneur

Well that was the new thrust of the comment and I don't have any other questions having heard that, that's great.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I guess I'd like to point out that in the third column the CPOE piece this is an example that Steve Posnack was speaking to earlier, the current certification criteria lumps medications, labs and radiology imaging into one certification criteria and ONC's direction is to break these apart as well. We weren't so smart as to recommend that in advance, but I think it is a good example of not all providers are doing all of this and allowing the vendors to more modularly certify could give them flexibility.

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

This is Jennie, I agree with that.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, maybe should we put a footnote in here? I'm trying to walk a balancing act between what's already in 2014 and what ONC has signaled for 2015 or should we leave all the 2015 stuff aside until we revisit it after March 11th?

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

I think having a footnote makes it a little clearer, you know, I mean, right now we've already started parsing out some of these long-term post-acute care, behavioral health providers as needing some functionality and I think this will be a further sub-setting because not all long-term care, behavioral health providers will need all three of these functions.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, we must be wearing everybody out, so let's add a foot note here and then we'll go onto the next slide. Liz?

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

Yes, so clinical decision support. So, basically everything in the left-hand column under clinical decision support is in Meaningful Use Stage 2. The middle column around quality measures really just references the request on this Workgroup to have the Quality Measure Workgroup discuss quality measures that could be relevant to LTPAC and behavioral health, so the recommendation being that this Workgroup consider the opportunities and report back.

And then the first bullet on patient engagement is around view, download, transmit. And this is one place where I think we need further clarification because we heard two different things and one was on the LTPAC side there was consensus around not including this in certification while on the behavioral health side there was support for including it but there were some concerns around omissions and modifications I guess to what is then passed on to downstream providers. So, I want to come back to that one, but then I'll just speak to the next two bullets.

The second bullet is around clinical summaries and the final one is around secure electronic messaging and those two – all of these of course are in Meaningful Use Stage 2.

Joe Heyman, MD – Whittier IPA

This is Joe.

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

Yes?

Joe Heyman, MD – Whittier IPA

I don't remember, maybe I'm just not remembering it or maybe I'm remember it about long-term care instead of behavioral health, I don't know, but I didn't think it was that crystal clear that we were recommending clinical decision support. I thought that we had a long discussion about it and that we didn't make that recommendation.

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

For which for behavioral health or for long-term care?

Joe Heyman, MD – Whittier IPA

For both. I know we had a long discussion about it, I don't remember us coming out with a recommendation to have it.

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

I think it was –

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

I think it was as long as it was modular then –

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

Yes, that was –

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

That's how we came to it.

Joe Heyman, MD – Whittier IPA

Okay.

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

That was my understanding as long as it stays modular –

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

Yes.

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

Then you could have that kind of module.

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

Right.

Joe Heyman, MD – Whittier IPA

All right.

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

And that's – so these are all modular for some LTPAC and BH providers.

Joe Heyman, MD – Whittier IPA

All right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

My sense from the hearing is we heard some examples of where clinical decision support was very helpful for picking up issues in long-term post-acute care not just on the ordering side but also on the monitoring side, but we also have lots of questions about whether systems were sufficiently sophisticated to have things well coded and if we were in a maturity situation here both for vendors and providers.

Joe Heyman, MD – Whittier IPA

I guess my concern about it was the cost, adding cost to people who aren't going to need it and aren't going to use it. But, that's okay, I don't feel strongly enough to die on my sword over it, just you can move onto the C-CDA part.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, so questions – so Liz was asking us to provide some further insight into the access information for view, download and transmit.

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

And so, Liz, what was the question?

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

So, the issue was that on the LTPAC conversation the consensus was around not supporting this for LTPAC but there was support for view, download, transmit in behavioral health there were just some concerns about any omissions or information that was not included in the information about view, download and transmit that would be passed onto downstream providers.

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

Yeah, so, this is Jennie, and I – similar, I guess it was to, I think it was Joe's comment just now, I don't recall the conversation not supporting this on the long-term post-acute care side and what's been on my mind lately has been for example person's with dementia, which is a common occurrence in nursing homes, may have caregivers for whom information should be/needs to be shared and made available too.

And so I don't know why this functionality would not be important to the long-term post-acute care providers or at least to some of them.

Joe Heyman, MD – Whittier IPA

I've got to admit, I agree, this is Joe. I'm wondering about the behavioral health side. It seems to me that they'll be instances where people's notes, a physician's notes or psychiatric social worker's notes, or something like that they may not want that downloaded directly to the patient.

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

Well, but then you always have, this is Mike, you always have that prerogative as a clinician to, you know, not allow the patient to have access to their chart, this, just because you're doing electronically it doesn't overrule the state laws on that and when you do that most states say "okay, you're not going to give it to the patient" but then you have to give it to the patient's guardian or to their legal representative and then they would still have access to do that.

But, you know, if you have concern about what you write in your note it's not appropriate for the patient to see. Other than that once the patient downloads their information they can decide whether they want to share it with anybody else or not, it's mine, so they're the same as everybody else even though they are a behavioral health person they're in control.

Joe Heyman, MD – Whittier IPA

Well, in any event I don't see why long-term care wouldn't have that same ability.

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

Yeah, I agree.

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

Yes.

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

I was just thinking clarification honestly.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

All right so maybe we're suffering from not all Workgroup members have been on every call.

Joe Heyman, MD – Whittier IPA

Well that's for sure and I'm going to miss Thursday's so congratulations everybody you'll save 10 minutes at least.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I guess what I'm hearing is that again we're reverting to modularity gives people optionality, that we're looking at summary documents here as well that are being made available to the patient for view, download and transmit, and so that this very well could be an area that would be supported by the, well not well could be, that this is an area I'm hearing the folks currently on the call do support for all the providers we've been talking about and we should remove Liz's qualifications about only some of our some and just leave this as broadly some providers would want this and it's of value in the setting.

Paul Egerman – Businessman/Software Entrepreneur

I agree, especially since we also have to keep in mind, on the behavioral health side, some of these providers are practicing in a multi-specialty environment. So, they're already using an EMR in it probably has view, download and transmit capabilities. So, I think it should be the same.

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

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay that's what I call –

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

Thanks.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, we're at 2:30, I think we're almost at the end, is that correct?

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

Well, we have two more slides.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Two more slides, okay. So, we should be able to pick those up on the next call.

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

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Why don't we go to public comment. I guess I'm supposed to make statements about next steps first. So, a reminder that we do have an upcoming call it's from 12:00 to 2:00 on Thursday and we'll wrap up the last couple of slides and these recommendations and then we'll – I think as we've got one open issue to CMS about surveyor access and then we will cycle back to some of our introductory slides that set the stage for the more detailed recommendations. So, with that –

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

Ah –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Go ahead.

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

Larry, this is Michelle, I just want to clarify on the next call it's a two hour call but we only have an hour to focus on this portion the other hour is to bring to this group the work that the Subgroup is doing.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Oh, good point, I said that at the beginning and I chose to forget that right now. So, yes, we'll be hearing from the Workforce Sub-Workgroup and they're making recommendations that also are under their own time clock going to the Policy Committee. The good news is that there is a little more breathing around those, but we don't know actually when the 60 day clock will start because the Department of Labor hasn't released their NPRM yet or their federal notice yet. Thanks for the clarification Michelle.

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

Thank you Larry and operator –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, let's go –

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

Oh, sorry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Let's do it, let's go to public comment.

Public Comment

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

Okay.

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue. We have no comment at this time.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, well thanks everybody for your efforts today, great discussion moving this along, it sounds like we're actually getting close to closure. Talk to you again in a couple of days.

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

Thanks, Larry.

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

Thank you.

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

Sounds good thanks, bye everybody.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Bye.

Paul Eggerman – Businessman/Software Entrepreneur

Bye.