



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

## **Presentation**

### **Operator**

All lines are bridged with the public.

### **Michelle Consolazio, MPH – 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 listing session related to long-term post-acute care and behavioral health as it relates to certification. Today's call will be a public call so as a reminder, before speaking please state your name. I'll now take roll. Larry Wolf?

### **Larry Wolf – Health IT Strategist – Kindred Healthcare**

Here.

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

Hi, Larry. Carl Dvorak? Donald Rucker?

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

Here.

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

Hey, Donald. Liz Johnson? George Hripcsak?

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

Here.

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

Hi, George. Jennie Harvell? Joan Ash?

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

Here.

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

Hi, Joe. Marc Probst? Marty Rice?

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Here.

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

Hi, Marty. Matthew Greene? Maureen Boyle? Micky Tripathi? Mike Lardieri?

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

Here.

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

Hi, Mike.

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

Hi.

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

Paul Egerman? Paul Tang? Stan Huff? Stephanie Klepacki? And from ONC, do we have Liz-Palena Hall?

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

Here.

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

Elise Anthony?

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

Here.

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

Lauren Wu?

**Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Here.

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

Any other – Jennifer Frazier? Any other ONC staff members on the line?

**Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation**

Hey Michelle, I'm here, Paul Tang, at least for the first half.

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

Hi, Paul. And with that, I'm going to turn it back to Larry Wolf. Just a reminder to everyone on the phone, if you are not speaking, if you could please mute your line, it would be appreciated. Thank you.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So hi, it's Larry Wolf. I'd like to welcome, everybody today. We're trying something different and very excited actually about this listening session. We threw a pretty wide net putting out to the world – the World Wide Web of please give us your input and we got some in writing and we solicited people to join us on this listening session. So hopefully today we'll hear some things we haven't heard, because these are new people, new perspectives. And so the panelists are going to be presenting, the workgroup members by likely to ask both pointed questions as follow-up and very broad general questions, as we try to better understand your point of view and the information that you are conveying to us.

And finally, to the panelists, the format here is that you have a few minutes to present and Michelle will be our timekeeper, to keep everybody on track. And so I know you've been thinking about what you're going to say so a reminder of, it's very hard to get everything into a few minutes, so really think about those key things you want to make sure we hear. And we can always accept additional written testimony if there's some background material that's important and there just isn't time to cover it today. So, I think that pretty much sets the stage.

I encourage everybody that we're here for an open dialogue and to explore the variety of points of view and to really understand what the needs are in post-acute long-term care and behavioral health, and where certified EHR technology could support that. And how that may play into existing programs of various kinds and what's already out there that people are building on. So we understand the state of today is well as the anticipated effort to take on some new activities. So, plenty from me, let's move this on. Michelle, would you introduce our first panel?

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

Sure, just a few ground rules. Just a reminder to all the panelist, you're public testimony is limited to 5 minutes, so we will have each member of the panel speak for 5 minutes. I will give you a 30-second reminder, but I will have to ask you to stop after 5 minutes, just so that we have equal amounts of time for everyone to share their perspectives. And once all of the members of the panel have been able to testify, we'll then open it up to the workgroup members for discussion. As a reminder to the workgroup, we're going to use the raise the hand feature, which will put you in the queue to ask questions.

So with that, on our first panel we have – and our operator's still getting everyone in on the phone, so if you could also let us know that you're here, that would be wonderful. So our first panel is quality improvement in health information exchange and our first presenter is Marylyn Harris. Are you here, Marylyn? Yeah, we haven't found her yet, so, Pamela Russell?

**Pamela Russell – Development and Outreach Manager – CORHIO**

I am here.

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

Hi, Pamela. Nancy Lorey?

**Nancy Lorey – Application Specialist – HealthLINC**

Yes, I'm here.

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

And Pamela Smithson?

**Pamela M. Smithson, MHA, RN – Director, Clinical Programs - Davis Medical Center**

Yes, I'm here.

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

Okay. So we'll start with Pamela Russell and we'll check in after Pamela, Nancy and the other Pamela have gone and see if Marylyn has been able to join. So, if you're ready, Pamela Russell, please go ahead.

**Pamela Russell – Business Development and Program Manager – CORHIO**

Thank you. Thank you Michelle Consolazio, Larry Wolf, Liz Palena and others from ONC and everyone else on the call, we are excited to be part of this panel on quality improvement HIE. My name is Pam Russell; I'm the Business Development and Program Manager at CORHIO, Colorado Regional Health Information Organization focusing on LTPAC providers. The CORHIO HIE and Patient Care 360 is a secure electronic network that enables healthcare practitioners to electronically share and access a patient's complete medical history and provide patients with better care. We are very excited about these efforts to combine LTPAC and behavioral health information and look forward to continued discussion and work with this group.

Since June of 2011, as a program manager of a 3-year LTPAC Challenge Grant to improve care transition and reduce hospital readmissions, along with Maryland, Massachusetts and Oklahoma, working directly with the long-term care providers. And in Colorado we have 130 plus providers live on the HIE receiving results, a majority of hospitals and labs in Colorado. Currently there are 24 behavioral health centers signed on to CORHIO HIE and in a January 2014, the Rose Foundation here in Colorado awarded CORHIO with a grant to improve health information exchange for behavioral health practitioners and patients. Traditionally behavioral health providers, primary care physicians and hospitals have been taking separate medical records for their patients and have had difficulty communicating relevant information with one another between patient appointments.

Currently the providers access, both long-term care and behavioral health access information that flows to the hospital's EHR vendors; in Colorado it's Cerner, EPIC and Meditech, except for sensitive information, which does include behavioral health. Our experience with the LTPAC providers is that they would really benefit by having access to BH data, especially regarding medications and behavior issues both prior to and upon admission to the skilled nursing facilities, LTACs as well as in-home health. CORHIO completed surveys in 2011 with the LTPAC providers in Colorado and our results are similar to what Larry Wolf and Mark Probst presented to the Health IT Policy Committee on March 11, 2014, that about 50% of the skilled nursing, home health and hospice providers use electronic records here in Colorado. But to date CORHIO is not integrated with any of the EHR vendors, but progress is being made.

Our experience with some of the EHR vendors targeted to LTPAC and BH sometimes lack the robust functionality, the HL7 needed to exchange that data effectively within HIE. And it's particularly true regarding granular content, which is needed to ensure that certain sensitive data, for example substance abuse treatment data regulated by 42 CFR Part 2, is only shared with very clear constraints on access. CORHIO has integrated our HIE with a number of EHR – behavioral health EHRs and more work needs to be done to ensure that the capabilities within these products to exchange information technology works within the physical health space.

Some of the questions regarding the technical interoperability requirements, I will cite a few and then we will be submitting written comments by midnight tonight for the public comment template for the proposed voluntary EHR certification. What CORHIO needs, especially results delivery is we can – we accept HL7 2.3 specifications. The EMR/EHR must also accept the HL7 observation result unsolicited, the ORU message. And that they can also send the HL7 original document notification and content, the MDN messages, if the receiving system can accept these. One thing that we really need with the LTPAC especially as the EMR/EHR must implement a patient matching algorithm and a reconciliation mechanism to its users are so they can manually link the patients that failed to match under the algorithm. With our physician providers using the providers MPI, we have that matching with the hospitals, not so much with the LTPAC behavioral health they – that without the physician matching, we will need that. So we do require they implement a patient matching algorithm.

And for und – we talk a little bit about CCDs – CCDs, but for Meaningful Use, and CORHIO also houses the Regional Extension Center and we did become early experts, certainly in the state along with our Meaningful Use recr – the REC, Regional Extension Center Board Members. So we’re working...Meaningful Use, but one of them was for the outbound CCD, the EMR must generate a CCD that complies with the Health Information Technology –

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

Thirty seconds.

**Pamela Russell – Business Development and Program Manager – CORHIO**

Okay, how fast am I talking – with the HIT – to standard, so we talk about – of the outbound CCD. Also very quickly, CORHIO was a HISP, so we have the ability to web-Direct secure messaging to be able to transport the CCDs through the Direct. And that is my opening – or that is my statement.

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

Thank you, Pamela and hopefully you’ll be able to finish out through the questions that are asked by the workgroup. Next up is Nancy Lorey. Are you ready, Nancy?

**Nancy Lorey – Application Specialist – HealthLINC**

Yes, I’m here. I just want to say that as an employee of the community health information exchange here in Indiana, I would like to endorse the voluntary certification and the standards that I’ve seen for long-term care and behavioral health EHRs. HIEs are all about care transitions and coordination of care, failures during transition of care are bad for patients. EMRs have a responsibility to ease those transitions of care and practices for behavioral health and long-term care have special needs for care transitions, since they are by definition serving patients that need or will need multiple healthcare services. And as Pam noted, a particular concern of behavioral health is management of consent for information to be shared.

While Indiana is an opt out state and most medical providers have structured their consent to allow coordination of care activities, behavioral health providers may view their records as more sensitive. And indeed in the case of substance abuse records, the provider must get specific patient consent to share information including with and through an HIE, except in the case, of course, of medical emergency where the glass can be broken. And this consent must include the party to which the information is going each and every time a record is released. The inability to manage consent leads behavioral health providers to prevent access to all information, not just that related to substance abuse.

And just as an aside, within our hospital, the stress care unit has its own medical record with no connection to the outside world and all care that happens on that unit is recorded in what I think of as a black hole record, even medical care. Providers have complained to me that they must physically go to the unit, even if they are a cardiologist or perhaps a diabetes doctor, to get that record and make a paper copy to actually take out of unit, even though most patients on this unit are not receiving substance abuse care. This approach adds risk to integrative care and is rather inefficient.

And for long-term care, care coordination is a primary concern of the EMR, since most of these – in most cases, at least in our area, long-term care patients will not be treated by on-site providers. And many people think of an EMR as primarily a place for physicians to write notes, whereas long-term care may be unique among widespread medical services in that recording encounter notes of physicians and advanced practitioners is not necessary or is not possible because that service does not actually take place in the long-term care setting. Instead, the nursing record becomes the focus. In this way, long-term care records are more like a hospital than an office. So the point of a long-term care EMR becomes recording the orders of the physician and recording how the orders are carried out by the nursing staff. Many hospitals have a way for physicians and other advanced practice practitioners to sign orders, scripts and transcription online. If a long-term care EMR could do this great, but otherwise secure communications of orders are key. The Director of our largest home health agency in our small community told us that if she could eliminate the task of tracking down paper orders and physician signatures, she could eliminate 1.5 full-time employees who do nothing but chase signatures for these orders. So an electronic form of orders would be key, in my view, to really making a long-term care EHR very, very valuable to the facilities.

Besides the immense task of orders entry and tracking providing the basic care coordination features could be of great help. And I can foresee long-term care facilities using robust data exchange as a marketing tool to patients, physicians and hospitals. If a long-term care provider could regularly update the primary care physician or other provider with vitals and point-of-care testing, it would be good business as well as good for the patient. And that's all I have to say, I think I'm under my time. Thank you.

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

Thank you, Nancy. Pamela Smithson?

**Pamela M. Smithson, MHA, RN – Director, Clinical Programs – Davis Medical Center**

Yes, hi, I'm an RN Director of Clinical Programs at Davis Medical Center in Elkins, West Virginia. And I need to say, I'm coming from a clinical perspective, my experience has been critical care, emergency department and emergency medicine with an integration of informatics over the years. Most recently, I've taken on developing the Davis' Telemedicine/Telehealth Program and this is growing in the state of West Virginia, because of the diversity and geographic location. So this is a program that has definitely identified that need for great communication and transfer integration of patient information among a variety of providers, the organizations and healthcare facilities, whether it's hospitals, nursing homes, behavioral health clinics or the LTPACs.

So once a teleconsult has occurred, how to get assessment, images, clinical notes, prescriptions from one provider organization or facility becomes the issue with secure, encrypted transmission, coordinated export format and then interoperability. Upon receiving USDA Grant this April Award to do telemedicine with nursing homes in our rural areas of our state, the nursing homes are in various stages of EHR implementation, as the other ladies have mentioned, 60%. Through IT support at some of the nursing homes, they've even advanced though to interfacing with our state's HIE, the West Virginia Health Information Network. And that's for purposes of providing patients advance directive pushes into the registry called eDirective Registry.

And I just want to say that as our hospitals are part of the eDirective Registry with the state HIE as well, we're able to view that nursing home residents info on their wishes. When they may have to come to the ED, so perhaps heroic measures are not instituted a the maybe had a new DNR applied since their last ED visit. The West Virginia eDirective Registry is the first online, all-inclusive, advanced directive registry in the US, to our knowledge, unless someone has something they can say.

But getting back to HIEs, they need to provide this real-time information for point-of-care decision-making as shown above and the HIEs can be of implemented in several ways, as we have worked on. It could be one, via the portal which provides the option to look up patient information within the HIE portal, but that information is not routed to the organizations EHR. Then there's integration through a trusted application, allowing for a folder in the participants organization's EHR where the patient information can be viewed, like the portal, but again it's not saved in the organization's EHR. And then there's currently patient information that can be routed in a CCD or continuity of care document and be stored in the organization's EHR or that information could be separated into different data elements and stored.

So moving to the talking points that I have provided a quick review. Our Davis Medical Center, we had developed a semi-electronic medical record back in 1990s, and that was mainly for nursing documentation and we're currently transitioning to the EHR platform that helps meet regulatory requirements and Meaningful Use attestation was done for Stage 1 and now working on Stage 2. For approximately five years, there's been use of a web-based platform that has provided connectivity services and integration among our hospital, physician offices and labs. And these hospitals and physician practices have already proven the exchange of patient health information is enhancing care in our local community. So the growth of HIE is increasingly being accelerated by those financial incentives available to the ARRA Act.

So many of the Meaningful Use objectives now require HIE capabilities and I really wanted people to know that the capabilities they should look for in the HIE is that provision of summary of care for patient transitions and referrals, submission of immunization data and prodromal surveillance to the Bureau of Public Health, which we do. Provide online access to health information that can be sent to the patient's personnel health record. And then record advanced directives, as I've said, through a state registry. Then you want to maintain privacy and security through authorized access and only by individuals identified with viewing patient information on a need to know basis. And then having that audit log so that you know the roles of those who are accessing the charts.

Reduce expenses with that HIE, it does help decrease interfaces as one connection to the HIE can enable connection with other healthcare providers, the labs, state regulatory agencies, as well as reducing those operating expenses that a lot of us are still doing to a certain extent with mailing, faxing, copying and storing paper records. And then we can increase the ability to participate in other innovative healthcare delivery initiatives, like our telemedicine programs or working with ACOs, patient-centered medical homes and then as we said, with behavioral health clinics, etcetera.

So in closing I just want to say that I feel the proposed certification criteria meet requirements for the delivery of more impactful care and facilitates faster, more effective data exchange. And this translates into more informed decisions that drive better outcomes and also reduces errors, which we all want. Thank you very much.

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

Thank you, Pamela. I think we have Marylyn Harris now. Just a reminder to Marylyn, you have 5 minutes and so whenever you're ready, please go ahead.

**Marylyn R. Harris, RN, MSN, MBA – President and CEO – Harrland Healthcare Consulting**

Hello, my name is Marylyn Harris. I practice in Houston, Texas. I'm psychiatric mental health nurse practitioner, a nurse for 35 years, a business owner of a healthcare consulting company and a behavioral health patient advocate. And I'm speaking today in support of endorsing voluntary certification and standards for behavioral health EHRs. I believe that doing this it's good for the patient, it's good for business and it's good for America. In terms of the patient, I believe it will reduce patient – the standardization piece. It will reduce errors. For the clinician, I believe it will improve clinician confidence and reduce errors. And for business, I believe it will enhance business opportunities and promote privacy and security in electronic health records. Thank you.

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

Thanks, Marylyn and thank you to all of our panelists. We'll now open it up to the workgroup members for questions. So as a reminder to the workgroup members, we're going to be using the raise the hand feature. So if you have questions please raise your hand to put yourself in the queue. Also as a reminder to our panelists, when you proceed to answer a question if you could just restate your name before speaking so we know who is speaking, we would appreciate it. So, Larry Wolf has a question.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Better take myself off mute. So, thank you very much for the wide range of comments we heard. A few people talked about the importance of exchange of the CDA documents and I'm wondering how much you're seeing that today, in terms of actual exchange and if you could comment on some of the specific things that are of value within the current specs for those documents. Or if you're running into issues because of what is or isn't in the documents or – we already heard some issues around consent with respect to 42 CFR Part 2, but otherwise, are there other issues with exchange of those documents?

**Pamela Russell – Business Development and Program Manager – CORHIO**

This is Pam – oh go ahead.

**W**

No, you please.

**Pamela Russell – Business Development and Program Manager – CORHIO**

Oh, okay, this is Pam Russell with CORHIO. Thank you, Larry. We actually have recently done a pilot with it's actually a hospital that has Cerner up in Northern Colorado. The idea there was to improve the care transitions between patients going from the skilled nursing back to the hospital. In meeting both with the hospitals and then with the skilled nursing, gathered a lot of really good thoughtful information.

From the hospitals' perspective, a couple things, one, even though the skilled nursing homes and LTACs do a lot – do a great job of copying and printing out a lot of information on the patient, which could include everything from med list, the nurses' notes and any of the current information. But many times the ambulance driver sometimes it may get lost there, it may – when it gets to the ER maybe it doesn't get past the ED Department, maybe the medical assistant there. So in the hospital the physician literally walks into the room and sees this skilled nursing patient. LTPAC patient, they basically say, we know no – we don't have any information about patient and then maybe order enough tests and procedures and so forth that already had previously been done.

So working with the skilled nursing facilities, and in Colorado we do have, for the HER vendors, I will do a shout out to Answers on Demand, work with Doc Devore, great job and a little bit with Point Put Care, not integrated but working with them. But many of the skilled facilities with Point Put Care use the interact tool and this is something that the hospitals are finding very important. So with the pilot through CORHIO as a HISP, I don't know how specific you want me to get, but we have the ability to give out the web direct messages. So between the skilled nursing facility and the ED department auth giving the username and passwords for the web Direct, we're actually just attaching and in the stakeholder and the groups meeting, what the ED really needs. And what we're able to transport is through the HIE product we have Patient Care 360, we have the ability to pull down what is called a CCD, we refer to it as summarization note. But it's going to have all the information, not only on the most recent hospitalization, but also if they were at other hospitals, other disparate systems, they're going to have the labs, the radiology, they'll have everything there.

They can create that summarization note. They can also pull the interact out of their EHR vendor, if in fact, the interact tool is electronic. They can pull out the advance directive, they can pull out the most recent med list, which is exactly what physicians and hospitals want to see on any patient, what is the most recent med list. And we're actually just attaching to PDF through web Direct. It's not the end-all be-all, it is not integrated with the EHR, it's not automated, but it is being able to send information electronically in a secure environment. There, and there was music at my end.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thank you very much for pointing out the value of having secure communication and using it for general attachments and not just the CDA documents.

**Nancy Lorey – Application Specialist – HealthLINC**

Yeah, and this is Nancy Lorey at HealthLINC in Bloomington, Indiana. And we're just – in our community working on just sending test patients via our Direct HISP, back and forth and seeing whether or not the EMRs can consume the CCDs and CDA – CCADAs, and we're having trouble. I think that a lot of the EMRs the functionality was tested with some vendors but not others and we're finding that the CCD documents, just the old-style – the old format, we are having some trouble with some of the vendors not being compatible with each other. And so we have a dedicated group of people here working with their vendors to try to do the beta testing that the vendors didn't do. I think the CCDs would have a great deal of value if people could integrate them. And so we're hoping to demonstrate that to our community, but it's rough going when you just have to look at it as a web document instead of being able to pull it in.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So thanks, a couple great perspectives on that.

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

Mike Lardieri has a question.

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

Yeah and thank you very much. And this would be jus – for just a follow-up on what you were talking about just now. What would make the CCDs not compatible across vendors, because I thought they had – I thought in order to get certified you had to be able to do that. So, if you could just clarify some of that?

**Nancy Lorey – Application Specialist – HealthLINC**

I'm not really sure. I'm a semi-technical person I'm not a programmer. I can parse an HTML document and – parse the XML to see what I can see from the standard of – I mean they look right in XML. So that's why we are working with vendors because everybody's working with the certified vendor and these are all just sort of flat CCD files. I think that perhaps that the testing – when you think about it, I think that we have well over a thousand certified EMRs under Stage 1, 2011 standards. And I think that it's probably just maybe an extra character at the end of the file that they just weren't expecting.

I don't think that at the time they did it that they anticipated all of the problems that might crop up from a different software vendor. And so I think that, like I said, we're doing their beta testing for them, maybe because it's a new EMR that's come out, maybe somebody's – I mean an XML, if you look at it, it looks very messy, so just a lack of testing. But again, I'm not certain that it's necessarily their fault, it's just that the programmer wasn't as flexible as they should have been.

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

And just to follow-up on that, so if we're going to focus on a modular approach and I'm a provider and I'm going to choose a vendor and I'm just going to choose the module that lets me data and privacy and security. If we're going to shore this up, what do we need to do on the front end?

**Nancy Lorey – Application Specialist – HealthLINC**

Well, from my perspective, from an HIE perspective, I mean we can – I think HL7 is a much better standard than XML for exchanging documents. And I think that CCDs can go into HL7s, I mean many – the ADT feeds from the hospital look a lot like the CCDs that are coming out of the EMRs, the end result of them. Of course the special characters that say that this is this data element are different than XML. So I'm not certain that XML is necessarily the best way to do a CCD exchange. But that's just from my perspective in an HIE. Where we get thrown – our infrastructure partner, HealthBridge in Cincinnati gets thrown tons of stuff from hundreds of different labs and they really don't have a problem getting through looking – taking the message and being able to tell what the data elements are there. So I'm thinking that perhaps as time goes on, maybe a different specification might help. Or we're just running into vendors where it's an extra carriage return at the end of a file and so it doesn't read it. Computers are very inflexible.

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

That's helpful, thank you.

**Nancy Lorey – Application Specialist – HealthLINC**

Okay, thank you.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Its Larry, let me just jump in on the tail end of what Nancy was saying and point out that HL7 labs have had a very long time to mature and HealthBridge has been handling that information for a long time. And we're looking at, if you will, a very short timeframe on the broad use of this CDA documents. So, good news/bad news is, we're learning and seeing that, as you pointed out, we're essentially in a beta test phase here as you're getting these documents and discovering that there are issues bringing them into the EHRs. And from the kinds of issues you're describing, it doesn't sound like we're at subtleties of code sets, it sounds more like we're at broad issues of actually reading the CDA document and correctly parsing get into sections even. Is that a correct characterization?

**Nancy Lorey – Application Specialist – HealthLINC**

Well, I – what we've run into is EMRs just basically throwing up their hands – one EMR will throw up its hands and say, this isn't a CCD or this isn't a CDA, the ones that say that they can handle both. Sometimes an EMR will not – will just say everything's – will not be able to read the specifics. The one that I deal with on a daily basis for one of our clients can't read allergies from Allscripts. And so I'm really thinking that we're just dealing with like little micro things that Allscripts has put into their CCD that is not read by another company and vice versa.

And I think that both of them are probably outputting CCDs or a CDA document and extended because I'm seeing that they do both. But using the extended language, their outputting's according to the standard, but when they read it in, they're just expecting something to be there that's not. And like I said, our community is starting cases saying here's the document that Viterra can read or Greenway can read and athenahealth can't.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Nancy Lorey – Application Specialist – HealthLINC**

And so the folks with athenahealth are going to their – athena and saying, everybody else in my community can read this, why can't you? So we're actually using sort of peer pressure on our vendors to get them to clean up the CCD exchange a little bit.

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

Um hmm.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So thank you for the additional commentary. So it sounds like the range of issues is from very broad, I can't read this document, it doesn't meet my understanding of the standard to –

**Nancy Lorey – Application Specialist – HealthLINC**

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– I can't import allergies to – all the other vendors can handle this document, the section of this document, how come this one vendor can't?

**Nancy Lorey – Application Specialist – HealthLINC**

Yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And so, a lot of different kinds of issues are getting shaken out here.

**Nancy Lorey – Application Specialist – HealthLINC**

Yes, yeah, and it's frustrating, but our group is dedicated to information exchange. And so they're really working on it and we're bringing on CarDon, which owns some local nursing homes and they are very excited about getting involved in this, too. And the CCDs and CDAs seem to be exported, even if they're not keeping a medical – a true medical record, the CCDs and CDAs are being exported out of practice management, too. So they can at least export a bit, maybe they're not picking up on – .well, maybe they are picking up on allergies, but we haven't really seen anything out of them yet, but we're really looking forward to dem – just basic demographics and insurances. Doctors don't have to worry about the business side of things, any little bit of data exch – interchange, if it can help them get through a little bit of their practice, and they can care for their patients better.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Great, thank you. Do we have other comments in the queue?

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

There's no one else with their hand raised.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Anyone else on the Workgroup want to jump in?

**M**

This is –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Hello?

**M**

Hi, can everybody hear me?

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

We can, but – .

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Are you one of the panelists, sir?

**M**

No. I had a question to the panel.

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

So the questions are really limited to workgroup members to ask the panelists, I apologize, but –

**M**

Sure. Okay.

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

Thank you. It sounds like we are ready to move on to panel two. So, on panel two, which is our patient, caregivers, provider and care team panel, we have Adrian Gropper, Monica Wafford, Sharon Hamilton and Rod Baird. So, as a reminder you all have 5 minutes and we'll start with Adrian, if you're ready.

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

Yes, I am. Hold on a sec. I'm Adrian Gropper, Chief Technology Officer for Patient Privacy Rights. PPR represents a coalition of 10.3 million people about control...concerned about control over the use of their health data. The lack of control has led to unwarranted risks and lack of transparency in all aspects of healthcare. We're all reaching the limits of patience with detailed regulations and certification mandates. Four years and \$24 billion later, physicians and patients have seen the costs go up and interoperability out of reach. For Meaningful Use must turn away from an institutional perspective and toward the patient-centered perspective that starts with – .pardon? Oh, with the physician-patient relationship and the real world family care team.

Our comments are in favor of increased transparency and accountability, increased access and increase security to enable the information to be available to the patient and to include with patient consent, the patient's family caregivers. EHR modularity is not a substitute for interoperability and can actually tend to increase the walls that define current health care silos. The modularity we seek allows the choice of information technology to be determined as part of the physician-patient relationship. The EHR certification criteria will not adequately serve the physician's responsibility to the patient if they restrict the ability of the physician to send complete data to any other destination with support for data segmentation for privacy, accounting for the disclosures, decision support, and patient-centered health records.

Full strength data accessibility is a market-based alternative to detailed technology regulation. Government efforts towards the Triple Aim must pivot away from an institutional focus in favor of physicians and patients. Our interoperability focuses on the transitions of care functionality accessible to physicians and to the transmit component of view, download and transmit accessible to patients and family caregivers. EHR certification criteria must focus on complete, timely, convenient and secure access as directed by physicians and patients with no interference from the institutions that operate certified EHR technology.

Complete information means that any information that institution share via any interface for treatment, payment and operations must also be accessible under physician direction via transitions of care and accessible via patient direction via transmit functionality. Complete also means that notes should be available and coding should be preserved. Timely means that information available via transitions of care and VDT should be accessible for decision support in real-time, from any sources that the physician or patient chooses and not just from sources controlled by the institution that happens to control an EHR. The delays in accessibility of information via patient-directed means must be under control of the physician so that the physician can decide what is best for our patients. Convenient means that physician, patient and caregiver authentication must allow for automation such as single sign-on and delegation to staff and family caregivers via widely available technologies such as OAuth and OpenID Connect.

From the patient and family care team perspective that are dealing with numerous separate patient portals, certified EHR technology must adopt OAuth standards to enable centralized access control and authorization management based on the UMA standards. Finally, secure interoperability requires data segmentation for privacy, the ability to respect voluntary identities for patients in cases where data segmentation for privacy is not deemed adequate by the patients, convenient delegation to family caregivers without the need to share passwords or otherwise allow unlimited and unaccountable access. And real-time accounting for disclosures to make it all manageable and transparent.

Behavioral health information is of particular concern to Patient Privacy Rights. We insist that data segmentation for privacy be implemented both internal to an EHRs institution and with respect to all interfaces. Within the institution, patient preference must be assignable by role or specific individual. For information sharing, patient data segmentation must be respected across transitions of care, delegated access via view, download, transmit and all –

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

Thirty seconds.

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

– treatment, payment and operations sharing as well. Finally, in summary, a pivot to patient and family centered care starts with the interfaces to certify the EHR technology. Thank you.

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

Thank you. Monica Wafford?

**Monica Wafford, RSST, CSSP – Advocate – South Oakland Shelter**

Yes. This is Monica Wafford, I'm with the South Oakland Shelter, and I'm the Housing Resource Coordinator. We've been in existence for 25 years serving the Metro Detroit area in Oakland County. We have various housing programs, supportive, transitional, and all funded through Department – of the HUD Department and we serve the community with resources, food and clothes closets. Also we have a lot of supportive services.

What I'd like to say is that I believe that it would be very important for us to share information, have this technology because we are, I often say, the crack that people fall into when they say people are falling through the cracks. The shelters are it and we receive people who migrate where services are. They often self-report. We do have – information system that we use, but there's very little health and behavioral information in that system. Also, our domestic violence survivors they usually are entered in as anonymous, which really doesn't help if there's an emergency, a medical emergency or crisis of some kind.

From as little as knowing food allergies to meds that may interact with each other for the pharmacies that we use, it would be very important to be able to know some things that people under – that are chronically homeless may forget or just not think it's important to let us know. We do have crises here where people we call an emergency vehicle quite often with people who we don't know anything about their health information and they come to us from another – they may even come from another state. So, I just would think that's very important that we know, especially for the people we serve. And that's it.

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

Thank you, Monica. Up next we have Sharon Hamilton.

**Sharon Hamilton, MS – Clinical Consultant – Briggs Healthcare**

Can you hear me?

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

Not very well.

**Sharon Hamilton, MS – Clinical Consultant – Briggs Healthcare**

Is this better?

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

Much better.

**Sharon Hamilton, MS – Clinical Consultant – Briggs Healthcare**

Okay, thank you. This is Sharon Hamilton; I am the clinical consultant with the Briggs Healthcare

Corporation. A lot of people may be aware of what Briggs is, we develop or we update documentation, or at least I do, for providers who are providing services in the home care setting. And generally those patients are using their Medicare or their Medicaid funding because they're receiving skilled nursing services.

But the real reason I'm speaking today is because I have 20 plus years' experience in homecare and I've had an opportunity to work on many systems in the field. And I think what of the biggest drawbacks to having many versions out there is that if you're moving from one homecare to another, you've got to learn the system all over again. It changes your workflow habits and when you're doing that, you're not necessarily being as efficient as you could be. So I see a lot of waste going on because we don't have standardization.

The thing that is the most paramount though is safety to the patient. And I'll give you an example of what it's like to be home care nurse when you're receiving information on paper. You've had patient let's say that was admitted to your services, you send them to the hospital for whatever reason and then they are discharged back to you. One of the things you have to do when they first come home is med reconciliation. I've often had patient that I've said with a list of certain meds and when they come back there are new orders, doesn't even look like the same patient sometimes because the orders are so different as far as their meds go. To do the med reconciliation, you're needing to call the doctor's office, find out why the meds were changed, just anything that you have to do to make sure that this patient is going to come home and receive the care they really need and avoid any mistakes that could have been done during handwritten transcription.

There are times when this makes it very difficult for the family also because they're asking questions, so it can raise anxiety level of the family as well as the patients and it gives the nurse a lot more busy work that she has to do. If there were a situation where everybody's on the same system, that nurse would be able to go in, access the records, see why the changes were made and verify that everything is correct to start out with. It would make it a much more seamless process to transfer that patient from any setting really into the home care setting. And I think that's about all I have to say, so thank you for your time.

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

Thank you. Ron Baird?

**Rod Baird, MS – Extended Care Physicians, PA**

– on the existing use of certified EHR technology by physicians working in on term post-acute care settings and I wanted to oppor – to identify some of the opportunities available as you're looking at voluntary certification for the long-term post-acute care facility community. My background is

managing a large physician and extender practice that covers 120 facilities in North and South Carolina. We've also developed our own certified EHR technology, it's 2014 complete, and we serve approximately 400 physicians in 18 states who carry this technology into facilities across those states. I'm formerly an innovation advisor with Medicare, working on long-term patient-centered medical homes and work with NCPDP and American Medical Directors Association.

There's an opportunity to leverage the use of EHR technology by physicians when developing the certification standards. There are about 5000 physicians and extenders in the states who provide more than 50% of all care in the nursing homes as the on-site medical care team. The majority are eligible for both Medicare and Medicaid Incentive Program and many are already carrying EHR technology in the facility that document and manage their practices. They also qualify for hardship exemptions because the facility EHRs are not designed to support Meaningful Use by those attending physicians, and that's the opportunity.

To talk a little bit more about long-term care physicians, they are primary care doctors for the patients in the nursing home while they are being treated, that's under Medicare regulations, and it's under the ACO rules and other – all the other rules for Medicare Shared Savings Programs. CMS tells us, or the large groups that we work with, that more than 50% of the patients we see are attributed to us as the primary care patient physician relationship. And under the ACO and value-based purchasing data that we receive back for the large groups we work with, the patients we serve, even after risk adjustment, place the groups at the 95th percentile of the most costly primary care groups in America. Which means a small number of physicians serve the most costly patients that the public pays for and there's an opportunity to improve that care by coordinating between the existing use of EHR technology by physicians and the facilities they work in.

One hundred percent of the physicians are covered under the Meaningful Use regulations, they are ambulatory, 80% of those and the nurse practitioners are also covered under Medicaid. And while they're unable to demonstrate Meaningful Use because of barriers, they are bringing this in our state more than 50% of all encounters are covered with a doctor using EHR. The barriers and they're not terribly high, large ones, but there are several. One is the inability to ePrescribe, that's because of the structural relationship between physicians, facilities and long-term care pharmacies.

Most prescriptions are started by telephone because of expediency and the need for workflow, happening immediately. The solution is there is an existing workflow standard created by the NCPDP long-term post-acute care ePrescribing Taskforce that is part of the NIST standard and part of the certification standards for ambulatory practices. If we incorporate that model in voluntary certification, that barrier will fall.

The second barrier is communication with patients; this is what Mr. Gropper was commenting about earlier. Physicians are taking care of patients in long-term care; the patients are usually cognitively impaired or just coming out of the hospital post-surgery. They themselves do not have access to the Internet, you have to depend on working with their surrogate, but we don't meet the surrogate, we don't have a way of understanding how to contact them. So as we're doing voluntary certification, a solution should be identifying the need to connect the physician with the surrogate for the patient via the facility's EHR. So we'd encourage you to consider that in the specifications for voluntary certification.

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

Thirty seconds.

**Rod Baird, MS – Extended Care Physicians, PA**

So finally, the opportunity when long-term care physicians Meaningful Use EHR technology, their work product is highly valuable for community-based physicians and hospital physicians. It is already created in a C-CDA; if they're using the most current technology demonstrated that works. And also, addressing the need to share data between the facility EHR and the physician's EHR in voluntary certification programs will yield immediate benefits for the public, consistent with the Triple Aim. Thank you.

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

Thank you and thank you to all of our presenters. We're now going to open it up to the workgroup members for questions. As a reminder to our panelists, when you go to answer the questions if you could please restate your name, it would be appreciated. And so our first question, Joe Heyman?

**Joe Heyman, MD – Whittier IPA**

Hi. Well first of all, I think we're sort hearing a theme about interoperability once again, how important that is and how it isn't happening the way it should. But I actually have a specific question for Adrian Gropper and I'm sort of sorry that he didn't speak before the first panel, because I think it would really have been helpful to get that their comments on this. He mentioned how important segmentation was within the EMR, but my question really is about health information exchange and segmentation. I'm not so sure how prevalent it is to segment an EMR – or to segment out sensitive information during health information exchange. And I would really appreciate some information about just how that happens, how often it happens, whether the technology is well developed and that sort of information?

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

This is Adrian Gropper. The best information Patient Privacy Rights has is that patients self-censor critical information because they cannot be certain that there are systems in place to segment the information when it's exchanged. We believe that – our research shows about 1/8 or about 37 million patients report hiding information from their physicians because of this issue. And with respect to particular behavioral health specialties, psychiatry and things like that, this is extremely common.

**Joe Heyman, MD – Whittier IPA**

Is there – this is Joe Heyman, again. Is there any information about health information exchange? I mean, our health information exchange is sort of an all or nothing thing. We warn the patients about sensitive information, we explain to them ahead of time that their – that if they have any sensitive information it will may be exchanged with other physicians and people who they might be uncomfortable about knowing it. But –

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

Yes, there's actually – I am on the state health information exchange and the Technology Advisory Council in Massachusetts, for example. And basically no, we're not aware of any health information exchanges that even account for disclosures in a way that's understandable the patients, much less do any segmentation. We've testified in other federal hearings on just the problem of patient matching being done coercively and therefore eroding the trust in health information exchange. And we've heard from numerous people already this morning and the previous panelists that the lack of transparency and the lack of accounting for disclosures just results in lack of trust and undermines any kind of health information exchange.

Accounting for disclosures is really not that hard and the institutions that are sharing this information all can identify patients when they put up a patient portal. It's not that the health information exchanges do not include privacy preserving patient matching is a completely artificial issue once the institutions themselves, whether they're insurance companies or hospitals put up a patient portal they've obviously identified the patient and done it in a secure and HIPAA compliant way. Why something even as simple as this and patient notification, which is common in situations every other industry in healthcare – other than healthcare, we receive – patients receive messages from banks, from Apple when their password is modified as a verification. No health information exchanges we're aware of do either of these very common things today.

**Joe Heyman, MD – Whittier IPA**

Okay, thank you.

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

Larry Wolf has a question.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, thank you. Gosh, I've got like a whole long list of questions. So let's start with some of the pivot to the patient centeredness that Adrian was talking about and I'm particularly concerned, you several times referenced the need to transmit information. And this was a hot topic at some of the recent Policy Committee meetings, the hearing we had a couple weeks ago on aspects of the current certification program that don't seem to be meeting a real need. And you kept referencing transmits. So could you speak about the aspects of transmit that you think our important and where things are currently working or where you're having problems with what's in place and you'd like to see some other things done around it?

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

Thank you, this is Adrian again. Yes, transmit right now is – does not have the kind of automation that makes it useful for broad-based health information exchange or patient directed health information exchange. So specifically in the Blue Button Plus group, the S&I framework group that we worked on, there was a lot of work done on automating the transmit function so that it could be triggered to facilitate, for example, medication reconciliation and the involvement of family caregivers that previous speakers mentioned. We also put in the Blue Button Plus Initiative the accessibility of RESTful interfaces such as the FHIR Initiative that people before me spoke about the difficulty with C-CDAs and the need – and the lack of interoperability when you have thousands of certified vendors.

One of the reasons of these things fail is because they're very, very broad and the errors don't show up by the time when you connect. Secure e-mail is great, but it's a very inconvenient way for developers to test for incompatibilities, because the error messages may not show up for days if not hours. So the design of the patient portals and the patient directed exchange opportunities really, the goodness has been worked out in Blue Button Plus and this is not – it was worked out with the vendors and a very broad community. The adoption of Blue Button Plus, however, is voluntary and has not proceeded into the marketplace. So it is very important that we follow through that the certifications follow through on very straightforward interoperability features such as Blue Button Plus.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Great. Thank you that was actually very hopeful, your specific comments around the Blue Button Plus and the S&I work and the lack of adoption you're seeing, even though you believe it would actually be a very helpful approach to addressing this stuff.

So I wonder if we could shift a little bit. We heard a variety of other comments – let me find my questions here. So, maybe we could pick up a piece that Rod raised, Rod Baird raised, about physicians are coming into the LTPAC settings, potentially behavioral health, some of the behavioral health settings as well physicians, physician extenders and they're bringing with them the physicians outpatient, if you will, ambulatory EHR in some kind of, I assume, portable, mobile form. And so then we have that activity happening in the physician, physician extenders EMR, but it's not connected to the facility's EHR where the patient's currently living. So, I wonder if you could talk about that dynamic and how – a little bit more and how you see that playing out.

**Rod Baird, MS – Extended Care Physicians, PA**

Well, this is Rod, thank you Larry. We've worked on this from various angles. We've tried at the top level through HIEs, that's awkward, that's a really excellent thing for transition of care, but what we're actually talking about in the nursing home is shared care or the virtual care team as the long-term care side of the equation for – do it, and that is the need to share care concurrently. The NCPDP three-way ePrescribing model actually has created a working model where the facility is in control because the facilities' record is the patient record of – the official patient record, they are the host. The doctors are bringing their record in but the doctors are regulated by a whole other set of policies that govern them as ambulatory physicians or outpatient physicians, ambulatory is the exact term.

So we needed to come up with a way that intersects the world of the facility, the physician and the pharmacy. All three people were or all three disciplines manage the same patient in the same bed and we've built that around ePrescribing because that was the first use case, it also allows for the facility to synchronize through a standard message called the census message, which is an NCPDP standard so everybody is identified. So in essence, it's like a private HIE where the facility has associated the physician and the pharmacy with the patient, they're in control and then everything is exchanged in the secure bubble, meeting the concerns that Adrian was mentioning earlier and some of the HIE folks had mentioned. But it's a push message, not a pull message. so it makes it flow into all three parties EHR technology. Did that help, Larry?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So that helps. So what I'm hearing is this is not – so, very helpful – say the basics. This is not transitions of care, end of care in one setting transitioning to a different setting or a different provider, but concurrent care, I thought that was great the notion of shared care. And that this is much more granular in terms of the need for interconnection and that the example to look at would be the kinds of transactional connectedness that happens around ePrescribing, specifically the three-way communication that's part of writing prescriptions in this setting. And that might serve as a model.

**Rod Baird, MS – Extended Care Physicians, PA**

Yes, yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I guess I'd ask one other piece. So I see where that would go – so I'm hearing two key pieces where the physicians and their extenders, nurse practitioners would sort of fall into this as well, where things like orders, more than just pharmacy orders. It could be a lab order, it could be a nursing intervention, could be a variety of things, so the things that the physician, the nurse practitioner might be writing as orders, that needs to be synchronized, if you will, between their system and the facility system in order for it to actually be actionable. And clinical documentation, right, so might be a progress note, might be history and physical that there might be a need for the physician to have that in their system as well as for that to be in the facility system. So your thoughts about how those kinds of things might coordinate?

**Rod Baird, MS – Extended Care Physicians, PA**

Thank you again for – I love those leading questions. We've already anticipated that and the NCPDP model while it's specific for pharmacy was written extensively so that it can incorporate other types of orders in that three-way connection. And it does not have to be the pharmacy as the third leg of the triangle, it could be a lab, it could be a portable x-ray company, for example. So the NCPDP standard allows for the incorporation of the C-CDA, and we've already tested this and it works that could incorporate any type of order and also provides for a secure electronic signature, which meets the regulatory standards for the pharmacy and the facility assuming it is adopted policies for eSignatures. And that is a CMS survey and certification standard so there is something to plug into.

So yes, you can accommodate all of those other orders and when the physician uses 2014 technology, which they're pretty much mandated to do, they actually have to be able to create a C-CDA and would have consumed all the information from the facility. So even if the facility is running behind on its adoption, the physician has information which could then be transported through an HIE or a Direct message to a hospital or community health system. So it helps facilities leapfrog some of their own problems because the lar – it's just very difficult to move this out into all the facilities across America, it's an adoption problem. Physicians are much more flexible because they have much less infrastructure needs. So it's a short-term patch to achieve some of the longer-term solutions that you guys are talking about.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I think that's a very interesting thought about extending the NCPDP structure for other settings beyond pharmacy. That was really helpful. Thanks, I think –

**Rod Baird, MS – Extended Care Physicians, PA**

And it does allow the consult – it allows the consulting pharmacist already in the model to be involved in that, so it already handles more than three connections.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Great. So I think that was it for me, Michelle, on this one.

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

Thank you. Mike Lardieri?

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

Yeah thanks, Michelle. I guess I wanted to get back to the areas of data segmentation and how that's going to work. I've worked with the number of HIEs and the data segmentation isn't there yet, probably not going to be there for another three to five years, by the time all the EHRs are able to segment the data and then send it to the health information exchanges. And I heard Mr. Gropper talking about using data segmentation extensively and Ms. Wafford was talking about patients that she sees in the shelters maybe are not so concerned about data segmentation because they want to have good coordinated care. That's the world I live in with more of the seriously mentally ill and usually patients who are both dual eligibles, Medicare and Medicaid and this is a group that probably is the 20% that's using 80% of the dollars.

So I'm wondering what suggestions or recommendations there are, what to do until data segmentation is ubiquitous across the country and all of healthcare? Any suggestions for that because I'm not sure how – for the 1/8 that don't want to share the information I'm not sure that I would want to hold up the other 7/8 of the patients who actually do you want to share their information with providers who are involved in their care. So I wonder if they have a suggestions for what do we do for the next three to five years until we get there?

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

This is Adrian Gropper. We've had this conversation with ONC and from a patient privacy rights perspective; the easiest way to achieve this goal in the interim is to allow for a voluntary and transparent identity management. In other words, the patients can decide, just like we decide now which email to use or which credit card to use or which phone number to give out, when we believe that segmentation of our information is important. This is something that can be supported in health information exchange and it has two benefits.

Number one, it's easily understandable by patients because they're already doing it in the other domains of their life. And number two, it doesn't clash – it doesn't impose the same difficulties and risks to the institution when they have to automatically figure out how to segment the data. In other words, the institutions are at risk as many people mentioned earlier, if certain pieces of say HIV information slips into a note or into the medication list by inference and that exposes the institution to liability. But allowing for voluntary identity management or self – or patient-directed control and patient-directed exchange in that way basically becomes a safe harbor for both patients that are very highly sensitive and the ones that like you say, depend on family caregivers and all sorts of other defaults for their help.

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

I guess I'm trying to understand then, just by having different e-mail address I still have sensitive data I want segmented, what I have one e-mail address I use for this set of data and another e-mail address I use for another set of data with another provider, is that – ?

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

Yes. And typically, like for instant if you look at that MyHealthVet patient portal, patients that sign in, vets that sign in are allowed to have a set of check boxes, maybe 20 of them, that determine what goes into that C-CDA or what goes into that the Blue Button text file. And that functionality has been in place for at least three years that is a data segmentation for privacy functionality. It is accessible to the patient and simply linking that functionality to the view, download, transmit function, in other words, where you type into the transmit box what the destination e-mail would be, which might be your health information exchange account or another EHR. So none of this – all of this is either 3-year-old technology terms of segmentation or already required by view, download, and transmit today.

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

Okay. And then when I send that information that has some stuff not in there, because I elected it not to be in there, does it give the provider any flag that, hey, there's other stuff here, ask the patient for consent or is the provider left blind?

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

The provider is blind and the perfect is the enemy of the good. We've had many conversations, I'm in the identity ecosystem steering group along with Dr. Tom Sullivan, I'm Vice Chair and he's Chair. And we have actually worked up in healthcare use case how to put the physician and the patient relationship first so that the physician is aware of wh – and is able to advise the patient about when there is a risk to doing that. So, just like we have different warnings and Blue Button Plus interface when patients are doing dangerous things, our opinion, as we move to strong cyber credentials and single sign-on and broad applicability that both the patients – and delegation, all of the things I mentioned. I think it's important to keep the physician in that loop, to make sure that the warnings that are given to the patient when they do segment information are clear, but eventually the only solution is to allow the patient to finally decide when all said and done. And again, that's what physician-patient relationships are for.

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

Yeah, okay. I'm a provider so I certainly understand that but I think we run a risk if we're sending incomplete data to providers and not giving them a flag, they're not going to the system. I'm a licensed social worker, I see psychiatric patients all the time, so why would I take that risk of even using the exchange. So I think we may have to strike some balance there, but I appreciate your comments. It's very helpful, thanks.

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

Thank you and thank you to everyone on panel two. I think we're ready to move onto panel three. I'm sorry, Donald Rucker, do you have a quick question because we are already over time for this panel?

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

I guess maybe the prior conversation Adrian entered, I didn't understand what coercive identity or patient indexing was. I don't know, we can defer that maybe later maybe that will come up in the vendor panel, but that was my question, what that was and –

**Adrian Gropper, MD – Chief Technology Officer – Patient Privacy Rights**

I can answer that very quickly. When the NSA does surveillance, for example, they basically match you – match the various things that people do across wherever they do it without any transparency and without any notification. In that sense, it is coercive. The subject never really knows what data was matched. And so we all have this – not all, but I'm saying it's typical to assume that electronic health records or digital technology is perfect. But that perfection is never achieved and the problems all happen at the edge whether you're talking about no-fly lists or NSA surveillance or automated and completely nontransparent health information exchange, all of these things turn out to have – to basically be unscalable to a regional or much less a national scale because you can't get the errors out of systems like that. You can make the systems automated, you can make them coercive but if you don't have the transparency built into it by accounting for disclosures and notification when the matches are made, then they become so brittle that people just do not use them.

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

Thank you. And again, thank you to everyone on panel two. We're going to shift now to panel three, which is our vendor panel. First up we have Joel from FEi Systems and then we have Scott from Kennebec Behavioral Health, Doran from LINTECH and then Rossmory from SigmaCare. So Joel, if you're ready. As a reminder to all the panelists, you have 5 minutes. I'll give you a 30-second warning. So whenever you're ready, Joel.

**Joel Amoussou - Health IT Standards and Interoperability Technical Manager - FEi Systems**

Yes, hi. So this is Joel Amoussou. I am a Technical Manager of informatics at FEi Systems. Thank you for the opportunity to speak today. I'm going to say a few words about FEi Systems. FEi Systems was founded in 1998. We are based in Columbia, Maryland. We are a Health IT solution provider and we are uniquely positioned for the this panel because we actually we are both in the behavioral health and the LTPAC services business. Our behavioral health EHR, which is called WITS, is used by 30 states in the country and we also have an LTPAC solution called LTSS, which is used by two states in the country.

We have a lot of experience with HIE, with content management and data segmentation privacy. We were a full participant in the ONC Data Segmentation for Privacy Workgroup and we actually completed a pilot with the VA to demonstrate the applicability of the ONC Data Segmentation for Privacy Implementation Guide. We are also currently doing a pilot right now with P. G. County, Prince Georges County, in Maryland and this is a pilot that will demonstrate in a real-world environment data segmentation for privacy within an HIE. We also have experience with clinical decision support and analytics. We have a grant from the NIH to do data analysis and predictive analytics on behavioral health data and we also have experience with CMS contracts.

I'm going to talk about now; I'm going to talk about the challenges – the integration challenges in behavioral health and LTPAC. As you know, not all behavioral health providers are eligible for Meaningful Use incentive money. And also the LTPAC providers are also not eligible to get EHR Incentive Program money. So that's one important challenge to integration there. The second set of challenges that in the behavioral health world, we have specific privacy regulations like 42 CFR, because mental health is often associated with substance abuse. And so there are certain heightened priority regulations, like 42 CFR, that we need to comply with, so that is a significant obstacle to interoperability, potentially a significant obstacle to interoperability between LTPAC and behavioral health. And so we need to have technology to capture and enforce consent, as well as to apply data segmentation before exchanging data. So that's a second significant obstacle to interoperability.

We also have a need to create lightweight and simple interoperability standards. Earlier one panel member mentioned the issues in exchanging C-CDA between hospitals. The C-CDA is quite complex – quite complex to understand the – issues when you try to exchange C-CDA documents in the real world. So we need lightweight and simple interoperability standards and Direct is a step in the right direction, Direct is for secure email, but we also need lightweight specification like OAuth 2 and OpenID Connect for authentication or there is another system called UMA, User Managed Access. So we need to have simple standards like that. HL7 is working on the FHIR specification, which is Fast Healthcare Interoperability Resources. And this is a RESTful specification for exchanging data and we believe that the FHIR specification is the future of data exchange because of the simplicity and because of the fact that it's a very RESTful oriented specification.

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

Thirty seconds.

**Joel Amoussou – Health IT Standards and Interoperability Technical Manager – FEi Systems**

Okay, so essentially our vision for integrated behavioral health data, we need to have eConsent management, the ability for patients to express their consent and to have access – full access to an audit trail of all access requests to their data. When need to have data exchange for assessment, we have a lot of assessment in behavioral health. We believe that a care plan is the backbone of care coordination and when he to have a data exchange standard for assessment and care plans. We also need to make sure that we can have interoperability between medical devices at home and each –

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

Thank you, Joel. I'm sorry, your time is up but hopefully you'll be able to finish through the questions.

Our next presenter is Scott.

**Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

Hello, my name is Scott Bressette. I'm calling from Kennebec Behavioral Health. We are a Maine company with over 300 providers. We have an EHR we have a self-developed here, we've been using it for 10 years. We were certified for 2011 ONC and we would like to contribute a few thoughts to this process in areas that we think that a certified behavioral health software should include.

In particular we want to start with that treatment planning; the short-term and long-term goals should be a part of any certified software. The ability to transfer a GAF, a Global Assessment of Functioning from the DSM IV or the WHODAS from the DSM-5, the general disability score. And transmitting DSMs between providers. In the proposed criteria for 2014, areas that work well for us are the interoperability and standardizing of codes such as RxNorm, SNOMED, LOINC, and ICD-10. Any time that these codes are pushed off that's actually harmful to us because now we have to maintain multiple codes sets.

An area of the 2014 certification that concerns us, if it continues into this area of certification, has to do with things like radiology. Not many of our providers, in fact, I don't think we've ever heard of a provider who wanted radiology in their software. Being able to, for Meaningful Use at least, transmit immunization and syndromic information, again very difficult for our providers to generate. And the way that we see this fitting into the 2014 certification as a way of improving the certification for behavioral health would be to exchange things in the problems list for DSM information and treatment planning. And then as well for clinical decision support, bringing in the DSM itself as discrete data would be very helpful. And in the area of clinical quality measures, including segments for been able to transmit the GAF, averages and such, and then having that by state, by region and nationally would be helpful to providers to find who is providing the best services for any given DSM.

In the areas of family health history, again genetics don't play a huge role in what we do, but certainly is a part of it, so we want to see some of that data captured. But also social history is an important aspect. And let's see, I think that's basically it, those are the contributions that we would like to add to this conversation and we'll be open to questions.

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

Thank you, Scott.

**Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

Thank you.

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

Doron?

**Doron Gutkind – Chief Software Architect – LINTECH, LLC.**

Hello, my name is Doron Gutkind, I'm a Software Architect of long-term post-acute care software solutions for LINTECH. First I would like to praise ONC for including long-term post-acute care in their initiatives, and also probably voice everybody in the industry's looking forward for the day that long-term post-acute care would also be included in some sort of financial incentive program.

I'd actually like to raise a few concerns with some of the certification requirements that are suggested by ONC. The first one is with the patient assessment piece requiring to support the ability to create, maintain and transmit assessment instruments. And we believe that all EMR and EHR products in the industry currently support that criteria and the only missing piece here is CMS. And we think that CMS should also be required to comply with these standards. They're currently receiving the assessment instruments in a standard that they have created, but they're responding with paper reports and we believe that they should also be required to send reports back in electronic XML form.

My second set of comments is mostly about the medication related requirements, the electronic prescription and documentation and reconciliation. In supporting the ability to electronically create and transmit prescriptions, and there are at least two issues with that. The first one is the RxNorm database itself. Long-term-care patients receive a lot of over-the-counter medications, and those are very commonly used in long-term care. Unfortunately the RxNorm doesn't contain all over-the-counter medications and vitamins. In fact, the RxNorm website says over-the-counter medications will be added and covered as well when reliable information about these medications can be found. So I think it's going to be very difficult to implement the standard of the RxNorm database in long-term care settings if the RxNorm does not contain all the medications that are being prescribed to residents in those facilities.

Further, many of the long-term-care pharmacies, which are external to the long-term care providers are actually not ready to accept RxNorm orders or can send RxNorm resident profiles, which be required to do all the reconciliation of the residents managed. And finally, the drug formulary database against which ONC would like us to check and reconcile any of the orders are currently only available in NDC format and maybe we can suggest that CMS will implement the crosswalk from those NDC to the RxNorm.

And just one follow-up on the HIE aspect of all the certification, I would actually like to comment that the current workflow is that when a patient is discharged from a hospital to a nursing home or another long-term-care organization, usually their discharge summary, again in CCD or C-CDA format is not available for few a few days until after the discharge, which is also the admission into the nursing home, which makes the exchange of that data completely invaluable to long-term-care providers. Thank you.

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

Thank you. Rossmary?

**Rossmary Gil – Market Strategist – SigmaCare**

Hello, everyone, it's my pleasure to be here today on behalf of SigmaCare. I appreciate all of the information that everyone has shared here today. I am Market Strategist at SigmaCare. We are an EHR vendor in the LTPAC sector. Our mission at SigmaCare is to help people lead healthier, longer lives by providing innovative technology and services that enable clinicians to provide higher quality healthcare. Among my multiple functions at SigmaCare, the key function I perform is to inform our Corporate and Product Strategies through detailed market research and analysis to identify macro and micro changes, which then translate into defining market requirements for new functionality in our EHR.

Given the perspective and insight everyone has shared here today, I would like to share key insights that we believe as an EHR vendor in LTPAC and also some of the key major market trends that we know is our foresight that currently the drive our understanding and delivery into the market. So as an EHR we believe that clinical decision support is key, much as the clinical decision support historically in LTC occurred in the pharmacy, and we believe that CDS is honestly was misguided incomplete. We believe that pushing clinical decision support into the facility and to the point-of-care will drive the highest value. We define clinical decision support, which I'm also seeing as CDS as interoperability, content and relevant longitudinal resident care that is acquired in a structured format in real-time, delivered in real-time to the appropriate caregiver and impacts the high-valued outcomes.

We also believe that in regards to interoperability, interoperability is vital as we all know for achieving a true community of care among the long-term and post-acute care providers and that there are essential networks from labs to pharmacies. That these organizations must share the clinical and the financial information for improved incomes – outcomes. It's also important to understand how this information exchange can provide a comprehensive view of a patient's health and what it means for their overall patient care, resident loyalty and even care safety. So from joining ACOs, which are certainly going rampant right now to simply bolstering the IT strategy clinically focused information exchange is at the core of financial success. And this ultimately enables long-term and post-acute care providers to focus on simplifying these complex steps such as medication management and preventative health measures.

As an HER, we also believe that advance analytics is key. Historically analytics have not been actionable because the data has been incomplete and siloed, as we all know. In addition, the ability to change behavior at the point-of-care didn't really exist. So honestly only through strong clinical decision support can the potential of advance analytics be realized and advance analytics, which we certainly believe will be a requirement of the market as we go through all the changes that have been going on and continue to go through them. We define it as operational metrics, competitive and organizational benchmarking tying cost to quality, which is really happening, disease management but trended over time, all of this trended over time. And I believe that taking all these key points and in alignment with the creation of the community continuum of care, EHRs deliver tremendous value to caregivers and the patients that receive their care. And we believe that there is opportunity to consolidate this value in the EHR to separate consulting services, technology enabled services and certainly we believe – solutions will emerge, as they have been, and garnering a premium price. But of course always looking to offer the end user a better workflow if it is integrated into the EHR.

And lastly, the drive and momentum of HIEs, RIOs and the group of integrators to create these clinical networks. These clinical network are certainly vital, and as much by a speaker earlier, I believe it was in panel one, they are allowing us to reduce the number of interfaces that need to be established. From our point of view as a vendor, it's reducing the number of interfaces we need to establish with other vendors and it's certainly reducing it along with the operating cost for our clients. Thank you.

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

Thank you and thank you to all of our panelists on Panel 3. As a reminder, when we ask questions, if you could please state your name before speaking, it would be appreciated. Are there any workgroup members that have questions? Well, if no work – okay Larry, please go ahead.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So we've heard several themes here that are consistent from earlier things we've heard. One of the things I didn't hear that may maybe as vendors you could comment on is the existing certification criteria, whether you've already been through a certification cycle, I think I heard earlier that the software that one of Rod's affiliated companies uses has been through that process. Have any of the vendors in this panel, have you been through parts or all of the current certification process and can you comment on what achieving certification and how you chose which or all of the criteria that you were certified against and thoughts about that process as we go forward?

**Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

Hello, this is Scott from Kennebec Behavioral Health. We certified for the ONC 2011 certification, is that what you're referring to?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Could be 2011 or could be 2014, yes, I'm referring to the ONC certification.

**Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

Okay. Well we worked for roughly maybe eight months to pull together from our existing EHR, again that was homegrown, in conjunction with RxNT, an outside vendor for prescription medications. And we certified almost in all areas, patient portals, problems list, medication lists and the providers here, at least our psychiatric providers, have really enjoyed that and it's been very helpful to them to have a standardized system.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So when you say standardized system, the fact that you are meeting the certification criteria, were you adding functions that you didn't have before or were you doing it in a different way that they felt was more standardized? Could you comment on what you mean by standardized?

**Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

Sure. Well, for us, we – the way that we had developed the software was basically what we think of in the clinical summary. So that way, their notes contain the active allergies, active medications, active labs and the clinical decision support that we added to it to help them make decisions. We were using the Class II and above drugs in conjunction with some of the psychiatric activities that they do, enhanced their notes. And as they were doing their work, they had a lot more information available to them. And when they were bringing up, and when they were providing it to other providers outside of our network, we use this CCR, which unfortunately we'll have to rewrite for 2014 certification, that again contained all the relevant information that they needed to transmit to another provider.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I guess what I'm hearing is, the certification process brought some additional structure –

**Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– to what had been just narrative notes and so now you could do clinical decision support because there actually was discrete data to do the analytics on.

**Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

Absolutely, and that's way they would like to see this continue to include things like treatment planning and the DSMs, because that is a part of their notes as it is now, but there's no standard way to transmit that to another provider. So having a certification system that incorporated more of these behavioral health elements would be very helpful.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. Thank you, that's very helpful to get those specifics. Anyone else with experience with the current certification?

**Rossmory Gil – Market Strategist – SigmaCare**

This is Rosemary Gil from SigmaCare. So, we are evaluating the criteria and we do plan to pursue certification. You asked in regard to any specific parts, we're looking at interoperability in both Stage 1 and Stage 2, given the need to coordinate care and given the new value-based reimbursement models that are emerging. So we are definitely looking at it, as I mentioned.

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

Joe, you had your hands raised, did you have a comment to add?

**Joe Heyman, MD – Whittier IPA**

Well, I heard several comments about clinical decision support including one from Larry just now. And it sounds to me like there are a whole lot of different definitions of clinical decision support. I mean, to me clinical decision support means something is recorded in the EMR and because of what's recorded, there's an indication that there are certain things that you might do. That to me is what clinical decision support is.

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

Um hmm.

**Joe Heyman, MD – Whittier IPA**

And if that's the definition, that's fine with me. If it's beyond that, I need to understand what it is.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So Joe, let me see if I understand what you're saying, and I think we are talking about two different things. So I'm hearing you say, you're including in your note, for example, the statement that says here's why I'm doing this thing or if this thing happens with this patient, here's what I would consider doing.

**Joe Heyman, MD – Whittier IPA**

No.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Is that right?

**Joe Heyman, MD – Whittier IPA**

No. What I'm saying is, I put into my note that the hemoglobin A1C is such and the chart automati – the EMR knows that this is a diabetic and that it makes a suggestion.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, so you're putting in a discrete value –

**Joe Heyman, MD – Whittier IPA**

Or –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Got it, got it, got it.

**Joe Heyman, MD – Whittier IPA**

Right, or I prescribe a –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

(Indiscernible)

**Joe Heyman, MD – Whittier IPA**

I prescribe a drug and there's another drug that the patient's taking that has a cross-effect with the drug that I'm prescribing and it pops up with an alert saying, Joe, do you really want to prescribe that drug?

That's to me is what clinical decision support is.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, good, so you and I are in sync then, we really are meaning the same thing.

**Joe Heyman, MD – Whittier IPA**

Okay.

**Rossmory Gil – Market Strategist – SigmaCare**

And I certainly – sorry, this is Rosemary from SigmaCare, and I certainly mentioned clinical decision support multiple times, provided the definition of what we look at it. But – so our definition that I mentioned, we defined CDS as interoperability, content, relevant longitudinal resident data acquired in a structured format in real-time and delivered in real-time to the appropriate caregiver and impacts specific high-valued outcomes. At the end of the day Joe, exactly what you said, it is what it is. There's so much out there and it's really working with key bodies, if it's with key physician like AMDA, key physician bodies looking at what CMS provides in the direction.

Everything that's out there, especially with quality measures, taking all of that into account and as a EHR vendor really taking that and driving it to the next level. Aggregating all this data, the data that's possible, the data that if it's the user themselves are able to establish this is the baseline for this resident. And if there's something entered whether it is an order prescribed, as you mentioned, it would be a DUR alert, that's something that we support. Things like that or if there is some sort of weight recording or anything like that that it's outside of the baseline of the resident, there's a support that can be provided to the end-user, to the nurse or that physician, so that they make the best decision.

It's not something that needs to, at least that's one of our perspectives that needs to wait to get to the pharmacy, like you mentioned with the drug being prescribed. If the resident is allergic to something, if there's a contraindication with another drug that is honestly the power at the fingertips of user with using an EHR that does provide that level of sophistication, that level of support. And a lot of focus, I know, especially in the industry with everything that's going on and quality of care focusing improving all of it, there's certainly a need and a continued focus that I'm sure will continue to happen. And it certainly this – a trend that is visible but not visible at the same time where you become stronger as an EHR? You have all this data, you have all this power, you have interoperability at the heart of this as well and being able to take all of that, aggregate all that data and add logics and intelligence and give that to the user so that they can start saving lives.

I know something that's great that's happening out there right now, it's not in LTPAC, it's on the ambulatory side, Google Glass being tested throughout. There are a couple of pilot programs, I know that there's a Rhode Island Hospital that's doing it. There's actually – we're based in New York City and I know Beth Israel, I believe I saw an article about two weeks ago that a doctor – it was in the Huffington Post – a doctor was able to save resident's life. The resident was not feeling well at all, couldn't communicate the allergy that they had on the drug. The doctor with Google Glass was able to pull up the resident's record in seconds and give them the correct medication and was able to save that resident's life. So there is definitely a lot to it and the connectivity is what's just going to keep blossoming and that's where it's great to be where we're at in today's day and age. And where technology is really helping to facilitate the day in the life of the doctors and the nurses to save lives.

#### **Joe Heyman, MD – Whittier IPA**

I guess what I'm concerned about is the idea that analytics – this is Joe Heyman again...that analytics are somehow decision – clinical decision support. I mean I think that goes way beyond clinical decision support. And I guess I would say the same thing about interoperability. I mean, I'm the guy who always says, hey, let's not forget what an EMR is originally for and let's try to use third parties to do the things that EMRs aren't supposed to do that other people want information from. I mean, I consider clinical decision support something that helps the clinician take care of the patient.

#### **Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

Hi, this is Scott from Kennebec Behavioral Health –

#### **Joe Heyman, MD – Whittier IPA**

– some third party to do measures, for example. I'm sorry.

#### **Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

I'm sorry. In my comment I was mentioning clinical quality measures – I'm sorry, clinical decision support and the DSM in the same sentence. And I just want to clarify that from a behavioral health point of view the Diagnostic Statistical Manual is a way in which they help decide how they're going to treat the patients. And it's not kind of – it could be either/or maybe in the specification of a certification, but they don't – one doesn't really replace the other, it's just what one is the most useful for behavioral health certified software.

**Joe Heyman, MD – Whittier IPA**

Got it.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

This is Larry, I actually want to clarify something. When Rossmar's talking about interoperability as relates to clinical decision support, I was assuming you meant that the code sets that are used for information that's exchanged would be consistent and interoperable. So that if they were imported into an EHR that that information would then be available for the decision support within that provider's system. And I know there are a lot of steps in what I described and –

**Rossmar Gil – Market Strategist – SigmaCare**

Rossmar again here. Absolutely, I mean from clinical decision support, it's not just based on your insulin or your blood sugar or blood pressure, this is the action you need to take or based on there's a contraindication with the drug. That's one level, at least as I view it, that's one level of clinical decision support, which is just the automatic things, for example when the doctor prescribes insulin and this is the dosing range based on this result, this is the dosing that you give. Things like that so like that's the basic and that's within medicine, that's at the heart of it, which physicians obviously obtain in medical school.

But I think taking that 1000 and above foot view, looking at everything that's possible it's not just taking that data which are best practices and guidelines and having that assist a physician. I think we're at a point and especially with HIT it's just – it's such a great ground to break to look at more than the best practices and guidelines and see how do we continue to expand that and help to connect the dots for the clinicians so that they don't have to struggle as much to make a decision. I know with the physician doing let's say his monthly, stepping into a facility, seeing the resident, looking at that progress notes, the vitals, the lab results, putting everything together and having to aggregate all that data to get to a conclusion of, do we need to change treatments?

It's with an EHR and being able to more easily access this data at your fingertips. It becomes more of a living and breathing system – organism that you're stepping into that can help a physician, a clinician to have that clinical decision support. So there's certainly a lot to it, as you mentioned. But that's just the 1000-foot view, as I mentioned, and going above and just seeing what can we connect for them and how can we help them enrich their workflows, enrich their lives so that they provide better care.

**Joel Amoussou – Health IT Standards and Interoperability Technical Manager – FEi Systems**

Hi, this is Joel here, can you guys hear me?

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

We can hear you.

**Joel Amoussou – Health IT Standards and Interoperability Technical Manager – FEi Systems**

Okay, I was trying to speak earlier, but I wasn't able. So I just want to make a quick comment about a couple of things. In the context of a home care, we believe that medical devices at home would be very important in the future, the ability to upload data from those medical devices into a remote EHR in the context of home care. And we'd like to see some interoperability there between those medical devices at home and the EHR at the providers. And also in terms of behavioral health, because of the privacy requirements we believe that we should have interoperability for consent, have robust consent management, the ability for patient to capture the consent. But to also have full access to their audit – to have access to a full audit trail of all access events to their documents and that requires standards like OAuth 2 and OpenID Connect and the use of – access specification.

We believe that we need to have standards for assessments, we have a lot of assessments in LTPAC, but also in behavioral health. We can reconcile some of those assessments, because they do have some common elements. We need to have also a very comprehensive data exchange specification for care plans. And we can also use those assessments to drive clinical decision support. So right now the assessments are really driven by government reporting requirements, but we can actually also use that data to do – analytics for – ability to predict hospital readmission risk for a patient or the ability to compare different treatments in the context of comparative effectiveness research. So those are the key points that we would like to suggest for future certification requirements for behavioral health and LTPAC. Thank you.

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

Thank you. This is Michelle, I'm just concerned about time, it's 2:55 and there are two workgroup members with questions. I think I'm going to have to ask that we unfortunately don't go to those questions because we need time for public comment, but I will defer to you, Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I guess I'd really like to get the questions asked, so at least get those out there and if we have to follow-up afterwards because the answers turn out to be complicated we could do that. So maybe just get the questions out there and then we'll make a judgment – get something quick, because you're right, public comment already started six minutes ago.

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

Yes, Mike Lardieri had a question and then Don Rucker.

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

And mine's not so much of the question but a clarification for Scott and maybe I can communicate with you off-line. But some of that work is already being done to add those data elements for – add the DSM V diagnosis, add data elements for social history and that kind of stuff. And I'll send you some stuff off-line, but that's happening under the ONCs Standards and Interoperability Framework Workgroup and it's called the – and it's the Community-based Collaborative Care Workgroup and folks at SAMHSA are leading that. And there's a group that meets every Tuesday at 12 o'clock and you'd be happy to join and I'll send you some stuff off-line about it. --

**Scott Bressette – Senior Software Developer – Kennebec Behavioral Health**

That would be great, thank you very much.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And Don?

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

Yeah, just I think for one of our other workgroups or something, we probably need to explore RxNorm and over-the-counter, what the issues are there. Because I think that would be an important thing for us to understand precisely, in terms of putting out language, just an observation.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sounds great. Okay, let's go to public comment.

## **Public Comment**

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

Okay, before we open the lines I just want to remind all public commenters that public comment is limited to 3 minutes and operator, please open the line.

### **Caitlin Collins – Project Coordinator – Altarum Institute**

If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press \*1 at this time. And I believe we do have public comment from Dr. Deborah Peel.

### **Deborah C. Peel, MD – Founder – Patient Privacy Rights**

Hi. Thank you for giving me this opportunity to talk. I don't know all of you on the committee. My name is Deborah Peel, I'm a practicing physician 35 years. I'm a boarded psychiatrist and psychoanalyst and I'm the Founder and Chair of Patient Privacy Rights and as Adrian said, we represent 10.3 million people.

I want to take a brief step back to talk to you all a little bit about the 30,000-foot level view. I want to tell you some things that I think are really important because I want you to understand how critical it really is to develop meta tagging for privacy and I think Cerner is doing that now and data segmentation. Because all of you are struggling to figure out how to help doctors and patients get the information they need at the right time and the right place and to protect it. But in the meantime, what we have is a system that leaks data like crazy.

So for example, at the Direct Marketing Association meetings annually, there are I think it's over 1000 companies that actually sell longitudinal profiles of people based on diseases. And a company that describes itself as the world's leading information services and technology company just went public and they create longitudinal supposedly anonymous profiles of 500 million people. I think that's all of us. And this is in their filings with the Security and Exchange Commission, they have electronic health records information, prescription records. They have claims data and they have social media. And they buy, sell, trade and aggregate this information with 100,000 data suppliers that cover 600 – no, excuse me 780,000 daily data feeds, this is health data.

So we're talking about, and even the vendors are talking about, the problem that doctors can't get information and of course, we represent patients. Patients can't get their information, but there is a giant health data broker industry that has all the detailed health information of every man, woman and child in this country. And our health data is accessed thousands of times a day because of the activities of these health data brokers and we don't know about it and the leading company sells our data to 5,000 clients, including the United States government. So this con –

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

I'm sorry Dr. Peel, your time is up, but we can –

### **Deborah C. Peel, MD – Founder – Patient Privacy Rights**

– that's why we needed a segmentation and we need data tagging now, because people will not trust electronic health records.

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

Operator, do we have any other public commenters?

### **Caitlin Collins – Project Coordinator, Altarum Institute**

We have no additional comment at this time.

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

Thank you and thank you to all of our panelists for joining. We really appreciate you providing your time and your feedback. And, thank you.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

This is Larry. Just to do a quick wrap up. We've got an upcoming meeting of the workgroup and so we'll be folding some of this into our final comments back to the Policy Committee. Appreciate everybody's time today, it was a really good discussion and thank you to the panelists especially, this was all done on very short notice and appreciate your taking the time to speak with us.

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

Thank you.

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

Thanks everybody. Bye, bye.