

**HIT Policy Committee
Certification/Adoption Workgroup
Transcript
April 28, 2014**

Presentation

Operator

All lines are bridged with the public.

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

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

Larry Wolf – Health IT Strategist – Kindred Healthcare

Here.

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

Hey, Larry. Marc Probst? Carl Dvorak?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I'm here.

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

Hi, Carl. Diane Bedecarre? Donald Rucker?

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

Here.

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

Liz Chapman?

Elizabeth Chapman, MS – Program Analyst – Veterans Health Administration

Here.

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

Liz Johnson? George Hripcsak? 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

I'm here.

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

Hi, Joan. John Derr?

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

Here.

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

Hi, John. Joe Heyman?

Joseph M. Heyman, MD – Whittier IPA

Here.

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

Hi, Joe. Marty Rice? 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 – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Paul Egerman? Oh hi, Mike.

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Hi.

Paul Egerman – Businessman/Software Entrepreneur

And Paul Egerman too.

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

Paul Tang? Stan Huff? 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 – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hey, Liz. Kate Black?

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

I'm here.

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

Hi, Kate. Jen Frazier or Elise Anthony? Lauren Wu?

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

I'm here.

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

Hey Lauren. And with that, we'll turn it back to you Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I'd like to welcome everybody. I think we've got a pretty interesting and full agenda for today. Do we have an agenda slide? Is that the next slide?

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

We should.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thanks. So, we've got a summary deck of our comments on the NPRM for us to review. These are going to be presented to the Policy Committee on Tuesday. We also have some updates on where we are with the behavioral health and LTPAC certification work that we were doing prior to reviewing the 2015 edition NPRM. So there are a couple of slides of summary of really where that work is and those will also be presented to the Policy Committee on Tuesday. And we'll be getting updates from the Privacy & Security Tiger Team and the Quality Measures Workgroup, and those folks will also be presenting to the Policy Committee on Tuesday. So, a bunch of stuff that's in prep for Tuesday's Policy Committee meeting.

So, we're going to have – we're going to try some time management magic today. So at 1 pm Eastern, we will finish the first the first two items so that we can hear from the Tiger Team and the Quality Measures Workgroup, and they'll have half an hour each. So we should use our time advisedly as we go through the material, reviewing the 2015 NPRM. I'm happy to dive as deep as people want to go, but we've really just got the hour to review the set of slides.

Paul Egerman – Businessman/Software Entrepreneur

And Larry, this is Paul, a quick question. What is our role when we listen to the Privacy & Security Tiger Team and the Quality Measures Workgroup? In other words, are we simply being informed or are we supposed to be making any comments to help them. It seems like they've already – perhaps already met, so I'm just trying to understand what we're supposed to be doing when we get those updates.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, so they're supposed to be reporting back to us on their take on how the work that they've historically done, how they see LTPAC and behavioral health. And so this is, I'm sure that they will be welcoming any comments from us in advance of what they might hear on Tuesday. And I'm not exactly sure where they've wound up, so, I'll be learning along with you today.

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

This is Michelle. Just – I just want to clarify, so they'll be sharing with you more for informational purposes, but as you know, the workgroups report up to the Policy Committee, so the Policy Committee will ultimately approve their recommendations, but you all had asked for this work, so they wanted to inform you of what will be presented.

Paul Egerman – Businessman/Software Entrepreneur

Okay. And so it's – but it's not appropriate or helpful for us to give them any feedback, in other words, we just listen.

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

I'm sure that they would welcome feedback, but you all aren't approving their recommendations if that makes sense.

Paul Egerman – Businessman/Software Entrepreneur

Okay. Thank you.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, any other questions about what's on our plates for today. Let's go on to the next slide. So this is what we've got scheduled for the next little over a month, from now through the June Policy Committee meeting. So the first item is today's meeting, 5/6 is the Policy Committee meeting on Tuesday. We're going to be posting RFI blog on LTPAC and behavioral health, looking for additional feedback from people about those care settings. And we are going to have some upcoming listening sessions, jumping up ahead to May 13, to get additional input from folks.

Next week as well there are going to be a couple of days' worth of hearings on certification. Marc and others have been helping organize that and Michelle will give us a quick update in a minute on that, I just want to finish what else we've got in our sequence of things. We'll have a chance to get together ahead of the listening session, so sort of review where we are in advance of that, and then after the listening session, to update our recommendations on LTPAC and behavioral health, based on what we heard at that listening session. And then a final review of comments before we make recommendations to the Policy Committee on June 10.

And that's really sort of the end of the timeline that ONC was asking for input, as far as heading into the 2017 rulemaking process, in advance of the 2017 rulemaking process. But given the expectation we'll get feedback from the Policy Committee meeting on June 10, it was a reluctant agreement that they would take a final set of recommendations from us at the July meeting. But I think the goal is to get as much done by June as possible. So I think that's the highlights for what's in front of us.

Paul Eggerman – Businessman/Software Entrepreneur

So, I'm just a little confused. The June 10 and the May 22 update, is that only to the 2017 recommendations or are we updating the 2015 recommendations also?

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, that's a good point. So depending what we hear next Tuesday, we may get feedback from the Policy Committee that they want us to update stuff, but the goal was to try and wrap that up on Tuesday.

Paul Eggerman – Businessman/Software Entrepreneur

Thank you.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And to sort of – we've been doing some stuff in parallel here, so we've been doing both the 2015 response and we've been looking at behavioral health and LTPAC as input to the next major round of the rulemaking process. So, there's been a switching back and forth between those two sets –

Michelle, can you say a couple of things about next week's hearing?

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

Sure. So the hearing is Wednesday, May 7, the day after the Policy Committee meeting. And the goal of the hearing is we are three years into the Certification Program. And so we just want to, from an ONC perspective, take a look back, assess how things are currently going, and identify areas for improvement as we move forward in the Certification Program. There are four panels planned for the hearing, the first is providers. And the second is vendors, that is the panel that Marc will be on, so self-certifying organizations will also be testifying, so John Halamka from Beth Israel Deaconess and Marc from Intermountain will participate in the vendor panel. And then the certification and accreditation bodies themselves will be testifying. And then some private sector representatives will be testifying in the last panel of the day. So, we have a pretty full agenda, we're hoping to learn a lot and the following day, on May 8, is a half-day session for the workgroups to meet and to discuss recommendations coming out of the hearing.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Michelle, you said workgroups, so remind us who else is participating in this.

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

Sure. So we've invited three different workgroups to participate, so this workgroup, we know that you've been very busy with LTPAC recommendations and responding to the NPRM. We probably would have assigned this hearing to your group had that not been the case, but we are inviting and would love for this group to participate in the hearing next week. We've also invited the Implementation Workgroup on the standards side to participate and then specific members from the Meaningful Use Workgroup will be participating as well, and they also were part of the planning committee. Any other questions about the hearing?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well thank you, Michelle.

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

Yup.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And look forward to a couple of days of rich discussion, actually three days of rich discussion next week in DC on all these topics. So, let's go on to the next slide. Okay, summary, this is what we're going to be presenting next week, so next slide.

So this is the overall outline of what's going to be presented. There are some overarching introductory comments about our discussion in general and some broad comments about the NPRM. And then we organized these in what we thought were thematic way to look at what we reviewed. So, while we ended last time with incremental rulemaking, we're going to begin with incremental rulemaking and then pick up the discussion around complete EHR certification packages and ONC mark certify – marks, which all sort of felt like very broad things. And then 6 and 7 were some specific drill downs into specific elements within the certification, as is number 8 and 9 around Blue Button. So, that's sort of the structure of what we've got here. Next slide.

So overall, the workgroup has been supportive of ONCs intention to ease the burden of regulations. But, it's not clear that the – within the NPRM actually achieve that and so we have some specific things that will come up in the subsequent sections that talk about some of those things. But one of the major things that kept repeating was that the workgroup doesn't see certification as the way to explore innovations, that certification really needs to be sort of the end-point of when things have been understood and it's clear. And sort of the major issues have been resolved and we know things are in good shape to roll out broadly, but short of that, that there are other methods whether it's S&I Framework or grant programs of researching what's already out there in the field and in use or the existing standards processes. And just vendor and provider innovations that happen without outside impetus.

So there's a lot out there in the marketplace, but certification itself isn't really a way to further innovation, it's a way to really codify things and put it into "standards framework." And to that end, the experience with certification to date has been that it's often prescriptive and burdensome and that intentionally or otherwise, it has in some ways over-defined some of the requirements about how things are done. And for a variety of reasons including possibly short timeframes, a lot of things have been implemented very quickly, particularly around Meaningful Use Stage 1, where there's a lot of feedback about check box reporting that was added on top of existing workflow. So really looking to avoid that in the future, and I know some of the intention of ONC with looking towards a more incremental process was to try to create less of that slap something on top and allow things to evolve. But it's not clear that the regulatory framework is really the way to move that forward.

And we wanted to remind ONC of the framework that we had put together about where certification was valuable. And a lot of our discussion as a workgroup really centered on the second bullet about aligning with existing federal and state programs. And that we heard mention of potential other programs within HHS that would rely on the certification ONC was proposing, but we'd really like to see those programs take the lead, in the same way that Meaningful Use took the lead that then drove certification criteria. To have those other programs take the lead and drive certification in a similar way. That would also help bound an understanding of what the cost/benefit tradeoffs were because if it was part of a program that was funding something, then some of the benefits would be clear up front. So I think that was just the one slide on overall comments. Any reactions from the workgroup about whether this is actually correctly framing what we've been talking about.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

This is Carl, I thought it was wonderfully framed and wonderfully spoken.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, I agree.

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

Yup, Mike.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Good.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Don Rucker, ditto, yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. I should just – we'll take the audio of that and play it back on Tuesday and it'll be done.

Joe Heyman, MD – Whittier IPA

Hey Paul, this is Joe. I agree with everything that you said. The one thing that you mentioned that struck a chord in my mind was when you said the thing about check boxes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Joe Heyman, MD – Whittier IPA

And one of my concerns is that one of the reasons there are so many of those check boxes is because that's the easiest way for a vendor to make it possible to count. And it's really important to the end user that they not have those extra check boxes, but the result of that means much more extra work for the vendor in being able to count without interrupting the workflow for the person who's using the end product. So I just wanted to point that out and I don't know whether you need to say it, but I just wanted to make it clear that one of the reasons MU1 was so frustrating was because of those extra check boxes and it's really important that they don't have extra check boxes for the next phase.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. Thank you. Let's go on to the next slide – other comments? I'm sorry, I just heard static, was someone else jumping in?

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

That was just John Derr, I was commenting that I agree with your –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thanks, John. Okay, moving on to incremental rulemaking, so, our main point here was we like incremental, but wasn't clear that what was being proposed was actually incremental. So we think it's important to provide clear signals and where there are incremental changes and small steps, there are opportunities for innovation and a standard update cycle. However, we were concerned that the regulatory process really doesn't support the kind of flexibility that ONC was looking for. Because it does formalize things into regulations, and those have inherently long time periods in them and they bring in testing cycles and testing costs.

We also surfaced a concern about what constitutes standards that are ready for use in certification. And I think there was a strong sense from the workgroup that as much as new standards were very important to innovation, and were important to advancing new capabilities. That rushing those into certification created problems because the standard itself was often really in a test mode, it's the first release, and we want to get experience from use. So again, a sense of having a chance to get beyond pilots and balloting of standards and really build on things that we know are a solid base.

And there were concerns also about given the pace of change, whether or not this would support vendors keeping up. And I think I actually want to add, and providers as well, into that. Because to start we've seen many years between providers updating their software, usually driven by critical business needs and the whole process can get to be very both expensive and complicated and take a lot of time. So I think it's probably important to remind the committee as a whole, and ONC that the very pace itself can create issues with updates.

Joe Heyman, MD – Whittier IPA

Paul, this is Joe –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

Joe Heyman, MD – Whittier IPA

Another point that – about what you're discussing right now is that because of those updates, sometimes a particular vendor decides not to pursue the update, and then the provider has to make a decision about actually changing their software, as a direct result of the change in the requirement for Meaningful Use. Or an indirect result, because the vendor no longer wants to participate.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm. Yup. So I know that ONC tried to mitigate that by suggesting that this interim cycle was strictly voluntary, but I think Joe's point is very clear is that one of the things we've seen a shift in is that there was a large pool of vendors for Stage 1. And it's been cut down to about a third of the size for Stage 2 and while it's not clear that those number of vendors represents the number of installed products, but if you're a purchaser of a product from a vendor who decides not to continue down the certification road, it does put you at a crossroads. And there are many reasons you could be at a crossroads with a vendor, but this is just one more. So I think that's a good point.

And I wanted to capture some of the specifics that we talked about earlier this week about what would be incremental. And so we've shortened up the wording a little bit, but I think the essence of what was being talked about is here, that we want incremental updates, vocabularies and data definitions. So where it truly is kind of a point release on the use of standards, especially where those standards are really intended to be – in some ways backwards compatible, to move forward with those and to allow people to move on to the latest things. As well as looking at things that are strictly technical updates within the regulatory framework itself or technical updates to the regulations, and an opportunity to correct errors that were in the earlier versions.

And finally, that in other areas where ONC is simply looking to signal something, or is looking for input, that an RFI or an advanced notice of proposed rulemaking would be a better regulatory framework for acting in, rather than certification. So, other comments about this summary.

Paul Eggerman – Businessman/Software Entrepreneur

Larry, this is Paul, I have two comments. First of all, this is still – this is all very good, I very much appreciate your effort to capture complicated discussions, you're really doing an excellent job. My two questions is, I didn't understand what it means, technical updates, that sort of little bullet in the next to last bullet. And the other comment is, we did, in our last meeting, have a discussion about the costs section, where it was stated that the cost in the NPRM were low, but also did not include either deployment cost or ongoing operational cost by the providers.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Ahh. Very good point.

Paul Eggerman – Businessman/Software Entrepreneur

– to me that was an important concept that either here or in the previous slide we might want to include.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And again –

Paul Eggerman – Businessman/Software Entrepreneur

It seems to me that there was a lot of interest in that –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And this is Carl and by low, I think it's – feedback has been provided to ONC that it's off by a factor of 10, if not more. So I want to be – I think low is really – to be clear.

Paul Egerman – Businessman/Software Entrepreneur

A little bit of an understatement.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

Unless you write with a lot of "o's" in the word low, but we also have this idea that this was very low on the development side, the idea that it did not include deployment costs, either on the vendor side or the provider side or provider ongoing operational costs. That is useful to include in the evaluation of these items.

Larry Wolf – Health IT Strategist – Kindred Healthcare

That's great. Yeah, I think it's really important because the regs do require cost estimates and they need to be better than they are.

Paul Egerman – Businessman/Software Entrepreneur

And what does technical updates mean?

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I may have been inventing there. That was my thinking that there may, in fact, be reasons within the regulatory process itself where things needed to change. But, I'll put that back to any one of the ONC –

Paul Egerman – Businessman/Software Entrepreneur

Oh, okay, so that's more like certification process updates, because we did say it was okay to propose things like packages –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

So that part – so it's not – it's really just the wording. When you said technical, I was still thinking of the previous bullet like standards. So, it's really updates to the certification process and that makes sense or proposed updates.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Well, and Don Rucker –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Maybe we should talk about that as well. Maybe instead of saying technical updates, it should focus on certification process updates.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Well I think there's also the – this is Don Rucker. There's also sort of the product issue. I mean, when I saw that I sort of looked at that as no change in the functionality required fundamentally, but really a sort of very small percentage wise, based on effort, workflow, and sort of all the parameters of sort of what you might call line-item changes, more on the measurement side or the definitional side of things. And it's almost implicit that the software itself doesn't really have to change for this. Because once you have a technical update on software, a little bit of this, on some level, you're in for a dime, you're in for a dollar, right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

If you have to have something that propagates out to customers, that's a big deal, no matter what it is.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yup. My sense from the discussion is that in the same way that software often has point releases that are intended to address very focused changes that there might be regulatory needs to address very focuses things maybe needs to be spelled out more than just calling it technical updates.

Paul Egerman – Businessman/Software Entrepreneur

So, it seems like we just need to wordsmith this a little bit.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. I think what I'm hearing is that the focus on certification process updates is probably a useful thing to have in here.

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And there are corrections are probably the main things that we're looking at addressing.

Paul Egerman – Businessman/Software Entrepreneur

But I like the previous comment to that these are intended to be like minor and technical point releases, these are not intended to be big deals.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Paul Egerman – Businessman/Software Entrepreneur

So, however you capture that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. Great. So, any other comments on incremental rulemaking. Let's go on to the next slide. Just continuation of complete EHR, so this was one of those where we felt that the concept of complete EHR was tremendously appealing, but actually delivering on that concept was really, really hard. And so that there are five specific things that we were responding back to, and you can see, some of them go on for a ways, like number 1 takes up most of this slide. And the concept here was, what does it really mean to have a complete EHR? If you're a provider, you're in – you make certain choices about maybe some optional things you're going to do about which quality measures you're going to use, maybe which supporting functions you do or don't need to do information exchange or something else. And so we recognize that the concept is a tough one, that there is still value to providers in being able to say, this is what I need to do my job and to get paid under a program like Meaningful Use.

So let's do all five and then we'll come back and talk about what's here. Next slide, please. Thank you. So the next point was about if you're going complete EHR certification, that that's one test cycle, you bring your whole product, you go through one set of paperwork, it's one interaction with the certification body, the testing body and done. If you're doing modules, the concern is that each module has, in many ways, the same amount of overhead as the complete had, but now you're doing this for many, many, many more individual things. And so depending on how the testing and certification process is organized and paid for that that could be a very much more expensive way to get technology certified.

The next piece was the suggestion to break out certification for CQMs, because they seem to have been the biggest sand in the lubrication here, of actually getting through the process quickly. And they were the area that was hanging out the longest, in terms of getting final specs on the Stage 2 work. We'd like to continue modular. There are a lot of reasons why both vendors and providers might want to have modular certification, so we don't want to minimize the value in continuing modular at the same time that we're saying that ONC should assess what it can do about keeping some kind of complete function.

And then finally we talked about that there is value in having components that work together, but there's almost an impossibility of actually testing that, especially if you're looking for functionality across modules and functionality of modules across vendors. So our earlier recommendation, going back several years now, was that the testing process should not test for integration and that while that would be an important need, we don't see a good way to get from here to there within the current framework. So I think those were the highlights, so comments or clarifications or further questions about these two slides.

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

This is Mike Lardieri, I think the only thing I'd want to add is if – there was some discussion about some providers only – some vendors only sell all the packages together, they don't sell modular.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

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

So, I would just want to – if that's the case on the CHPL, that should probably be identified so the provider has an easier time of navigating that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so right now it shows you whether they're complete or modular.

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

Yeah, and if we're getting rid of complete, somehow it has to say it's only sold together, unless we –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Oh, I see what you're saying, if the certification is modular, but the selling is complete.

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

Yes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Got it. Any other comments? Okay, let's go on to the next one. This was the notion of certification packages. I think this is one that on the surface was pretty appealing, but as we explored it, we realized that it was really pretty problematic and so in the end we didn't support the proposal around having certification packages. And so the concern here is that really it wasn't clear how packages mapped to anything else. And there were issues about how things were named, there were questions about possible confusion that in the end, you would have to resort to the list of modules to actually know you had the things you needed, whether it was part of Meaningful Use or part of some other non-MU program. And so we were really left with the question of, what's the value in the package. So, any other comments about packages? Okay, let's go on.

Certification mark, so after a lot of discussion, it seemed like the primary issue here is one between ONC and the authorized certification bodies. That ONC wants a single certification mark rather than having each ACD create its own, which is what they've been doing. And so to that end, we support there being a singular certification mark. And then there was discussion about how this did or didn't affect how vendors presented their products and our understanding is that vendors are not required to use the certification mark. If they do, they would need to use the ONC one, but the extent to which they're focused on they want to keep other's logos off of their product, as it were, they could do that. But in terms of how the ACDs do their work that it would then be one certification mark as part of the ONC Certification Program.

And we didn't talk about this, but I guess I'm thinking about what I've seen the certification bodies do over the years and they create extensions, if you will, in other things they're selling and presumably this would help distinguish between the additional things that they're doing and the things they're doing that are strictly within the ONC framework. So any other comments about certification marks?

Joe Heyman, MD – Whittier IPA

Paul, this is Joe. I guess my only concern is that there ought to be a standard way of knowing whether something meets Meaningful Use or not and I don't know how to do that, meets the requirements of Meaningful Use.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right, right. And I guess in some ways it takes us back to the whole issue of complete, right?

Joe Heyman, MD – Whittier IPA

Right. And I guess it also has something to do with packages, I didn't say anything but, I will frankly admit to you that I don't understand what a package is, so I was keeping my mouth shut.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think the simple thing on packages is they were proposing that you could lump together or they would lump together groups of modules into a package and that using the package name might be an easy way to talk about related modules. But, my sense is that it was just adding noise to the whole story.

Joe Heyman, MD – Whittier IPA

Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

But, we'll see, we'll see if it resurfaces. Okay, let's go on to the next slide. So we have a pair of slides here that talk about non-MU certification. And this is really a very specific aspect of non-MU certification and this is really about the calculation of the numerators that are part of the Meaningful Use objectives. It doesn't talk at all about use of the certification process or the modules in other context outside of Meaningful Use, other than this calculation. And the suggestion in the material, in the NPRM, is that by separating out this calculation, that the software might be simplified and cost might be reduced and that that would be a good thing.

And the discussion of the workgroup was in many ways saying, we couldn't really assess whether that would significantly affect the cost, or if it would just add confusion in the marketplace. And while it might be theoretically useful, it would be just too hard to explain. And finally that there might be value to non-MU users in being able to get the usage statistics that are part of the MU version. So even if you weren't going after an MU objective, you still might want to know how much the function is being used. And now we get into sort of subtleties, right, because to Joe's point about well, if they've implemented it by having a check box, I would really like to get rid of that, so as a non-MU user, get rid of that so as a non-MU user, get rid of that check box, I'm happy. But if it's implemented in a way it collects the data, collects that numerator information without adding user burden, then I might be very happy to have it collect the data for me behind the scenes. So, it was more – a lot of gray here. Did I correctly represent the grayness that we were seeing?

Paul Egerman – Businessman/Software Entrepreneur

Larry, this is Paul, I think yes you did. Looking at the slides, I just had like a minor wordsmithing comment on the second bullet that says workgroup did not feel that the members have the knowledge or insight in order to determine the impact. I viewed that as like a refreshing statement of humility.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

Paul Egerman – Businessman/Software Entrepreneur

But I'm not sure that was what was intended, because I do think there is a fair amount of knowledge and insight, a huge amount of knowledge and insight in the workgroup. So –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Paul Egerman – Businessman/Software Entrepreneur

– that's just a wordsmithing observation.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so maybe we should shorten that up and say that we weren't certain of the impact –

Paul Egerman – Businessman/Software Entrepreneur

We – possible to predict.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

Did not feel it was possible to determine or predict, yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, we'll drop the humility and just jump to the bottom line.

Paul Egerman – Businessman/Software Entrepreneur

Well, it's just it's inconsistent with the other things we've done to show humility.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

Joe Heyman, MD – Whittier IPA

Also Larry, this brings up the subject of me calling you Paul, because I don't know whether –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Oh.

Joe Heyman, MD – Whittier IPA

– I should apologize to Paul or to Larry –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

Joe Heyman, MD – Whittier IPA

About the second bullet, so I'm apologizing to both of you.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, well that's fine.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

One comment – this is Carl – I'll add on that second to last bullet, the workgroup noted there's likely a smaller development requirement and cost for non-MU certification. I think that is only true for those vendors who don't also do MU certification, but if you're a vendor who has products in both spaces, you actually will incur a higher development cost. Because you'll have to have profiling or some additional elegance that says, oh, I'm an LTPAC and they don't like extra check boxes and buttons, so as long as they want to go see the problem list that's fine, but I don't need to confirm that they've reviewed it and attest that its complete.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

So I think it actually has a higher development cost for some and a lower development cost for others, and the higher is for folks who have products in both spaces that share some common functionality.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Joe Heyman, MD – Whittier IPA

They may even have a way of turning on and off the check boxes.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Well you can, right, that's programming, one can and often does in certain scenarios.

Joe Heyman, MD – Whittier IPA

Right.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

It's just that it's programming that a programmer does so somebody's got –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Has to be programmed, has to be documented, has to be tested, has to be trained, has to be – right.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Exactly, certified.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Certified, right, it has to be supported over time. Okay, so we'll make another pass on some of the wording on this slide.

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

Larry, I just want to point out we're 10 minutes before 1.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you. So, let's see if we can quickly go through the next couple of slides so we can get to our appointed time. We then had some general comments about things like many factors go into pricing, not just development costs or testing costs. Even if this simplifies the development cycle in and of itself that probably doesn't incentivize vendors to enter the space. In some ways it's referring back to our earlier statements about – that certification may have some values, but it's not around encouraging vendors to enter a space.

We felt like we were creating confusion by creating sort of multiple tiers of products that were very, very similar and there might be misunderstandings where people start buying other products because they think that they're either less expensive or simpler, and it may or may not actually be meeting their needs. And we didn't see a good way of representing this on the CHPL without continuing the confusion. So most of these bullet points are really expanding on what was on the earlier slide. So, since we are under time pressure, let me take a quick look ahead at what's coming up, see if we can't jump ahead. Okay.

Rather than walking – so let's jump ahead – so here's what I'm going to propose. Rather than going through the rest of these slides, that if the workgroup folks have comments or questions about what's on the additional slides about the NPRM, to get those back to me and the workgroup. You could just copy actually everybody if you want, or you can send it to Michelle and I and we'll do our best to incorporate the feedback as we go forward. I want to jump ahead to the slides on LTPAC, which we're going to be presenting as well on Tuesday. So let's go ahead a few slides, I think it's like 15 or 16, no, 18, slide 18. Thanks. So, and right, slide 19.

So, the top part of this should look familiar to everybody. We had identified a few areas of building on the existing certification criteria that's in use in Stage 2 as things that we would recommend for all providers, including LTPAC and behavioral health, for any group looking to certify things. And so one piece was privacy and security. And so we pulled out the block of certification requirements that are under the current privacy and security heading, and then we tagged those. So the blue grid – the green grid, rather, at the bottom, was a request from the Policy Committee that we take the same kind of grid that I think Meaningful Use Workgroup had used and apply it to all of our things. And so the way the grid is filled in is the focus area is the area of certification, so in this case, privacy and security. The type or the type of providers it applies to and then the three groupings of provider use effort, standards maturity and development use effort. And so the Standards Committee actually has put forward some measures for standards maturity and I think that doc – was that document supplied to everybody as well?

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

Yeah, that was included as supplemental material for the meeting today.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so it's a pretty robust document and in retrospect, it might have been helpful if we actually spent time going through it. But right now, we'll leave it as an exercise to the reader and maybe we should jump to some of our seat of the pants estimates for things here. So the feeling was that the provider effort here was low, mostly because these things are either behind the scene, they're embedded in the technology or they're part of system setup and wouldn't have a huge effect on the users. And that the standards themselves for doing these things are well established and that the relative development effort is low as well.

Paul Egerman – Businessman/Software Entrepreneur

So Larry –

Larry Wolf – Health IT Strategist – Kindred Healthcare

That says development use effort, it's not jus – shouldn't that just be development effort?

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

Yeah, we'll make that tweak.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thanks.

Paul Egerman – Businessman/Software Entrepreneur

So Larry, I'm confused, is this part of our 2017 recommendation or a 2015 recommendation.

Larry Wolf – Health IT Strategist – Kindred Healthcare

No, this is, we're now switching gears, so sorry. We're now switching gears from our response to the NPRM to the input on behavioral health and LTPAC for future rulemaking, presumably part of 2017.

Paul Egerman – Businessman/Software Entrepreneur

Okay, so this is not going to be included in your presentation on Tuesday.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So there's a separate presentation in the afternoon that looks at beha – so in the morning, presenting on the NPRM.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

This is now for the afternoon –

Paul Egerman – Businessman/Software Entrepreneur

Okay, so there – thank you, now you’ve answered my question. So it’s like everything that came before that is like one presentation.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yes.

Paul Egerman – Businessman/Software Entrepreneur

This is a totally separate presentation that will be – okay, thanks.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yes. Slide 18 is the break slide, we had actually thought about sending you guys two slide decks to make that really clear.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I got confused, okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

That’s exactly why we wanted them separate, good feedback, if only on style. So, questions or comments about this, substantive or style? Great, one easy one, let’s go on to the next slide. So this one’s now looking at transitions of care and we had made two – we’ve put out two items for recommendations, one was built on the MU2 material, so that’s number 1. And the second one is looking at things that have been proposed as part of the 2017 MU Stage 3 process, and looking to include those for this care setting as well.

In our review of this, again this is now for care coordination, it would be for all providers. We felt that because transitions of care affected workflow and that these were new capabilities that this was going to be a big deal for users, on the provider side. That there were established standards in place and that they’re getting beat on for Meaningful Use 2, so those were felt to be mature, but that the new material is a low maturity, that it’s emerging. It’s been through a ballot process, but it hasn’t had much real use, so a concern that for number 2 we have low standards. And in both cases that the development effort was high. If you’ve never created a CDA document, that’s not a trivial exercise, you have to have everything structured and coded in a way that you can bring the data forward, you can produce the standard document, that you can handle the required transport. So, a fair amount of pretty technical work – pretty specialized technical work to get this stuff going.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul. My comment on this is that it would be okay for us to say that the transitions of care documents for providers should be the same as what is approved for the Meaningful Use providers. But we should not be trying to specifically like put our seal of approval on what – anything specific that has been proposed, because it’s inconsistent with the general concepts that we already put forward.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

I mean, in the transition of care, specifications exist in the NPRM, the 2015 NPRM, I mean, that’s where you come across some of these things that have been balloted, but there’s no – there’s an implementation guide that hasn’t even been published yet. And that’s, at best, eyebrow raising because I don’t know how you can comment on a document that hasn’t been published yet or, I guess it’s easy to comment on, it’s hard to make a constructive comment.

Larry Wolf – Health IT Strategist – Kindred Healthcare

A reality based comment.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, so my suggestion is simply to say, transition of care is really important and we think whatever is ultimately approved for transitions of care should be approved for all providers. But we should not be giving the impression that we’re approving of the specific items that are in the NPRM.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, that's a really good point.

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

So this is Jennie and so just a couple of comments. In addition to transitions of care being really important, I think care plans, particularly in long-term post-acute care and behavioral health and maybe in other sectors as well, are also important. And in terms of the NPRM reference to the standard, the 2013 Consolidated CDA standard, just have a couple of comments on that point. I think this workgroup heard testimony about the utility of the Consolidated CDA refinements to support transitions of care and care planning that predated the NPRM publication. So, I don't think that in terms of our conversations about long-term post-acute care and behavioral health certification that the use of or value of the Consolidated CDA was raised in the context of the NPRM. It was raised simply in terms of the context of that HL7 standard and it's utility to support transitions of care and care planning in long-term post-acute care and behavioral health.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So Jennie, let me see if I hear what you're saying, that Paul's statement is true, in terms of we want consistency across all the care settings. And you're suggesting that, in fact there's been work done beyond what was described in the NPRM that would put a more solid basis under some of these things than what was presented.

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

Umm, well, so you want me to try it again?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sure

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

I agree with the premise of having alignment on transitions of care and care planning, across sectors. I think the alignment of standards and certification criteria is important. I think that was Paul's comment, so I agree with that comment from Paul. But I also want to say, and I don't know – it seems to me it should be communicated back to the Policy Committee that independent of and preceding the publication of the NPRM, this –

Larry Wolf – Health IT Strategist – Kindred Healthcare

This is – Jennie, the NPRM you're talking about is 2015 edition or you're anticipating the 2017?

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

The 2015 NPRM.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

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

Yeah. That independent of that and preceding the publication of the 2015 NPRM, this workgroup heard testimony from different people about the value and importance of the Consolidated CDA that was being balloted in 2014 to support both transitions of care and care planning. And that testimony that this workgroup heard was in the context of long-term post-acute care and behavioral health but, just my opinion, I don't think it's limited to only those sectors, I think it's – the Consolidated CDA – in terms of ToC and care planning, will support healthcare providers across the care continuum. So I just – I would like that part of the message also to be communicated back to the Policy Committee.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I'm hearing – so, Jennie, what I'm hearing you say is, without commenting about maturity or not maturity of the standards, that there's a need out there to do a better job of supporting care planning as patients transition from setting to setting, and that HL7 through the CDA balloting is moving that forward. And so at the least we should be, we meaning ONC, should be assessing the developing maturity of those standards as they look ahead.

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

Correct, particularly calling out in the context of ToC and care planning.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. So to highlight care planning as an element here.

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

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so I'm seeing that that is what's in the text of bullet 2, right, support the inclusion of emerging ToC and care planning, so, that this is what we heard in our work and that the concerns we have are not to introduce something special for one care setting that needs to be broadly implemented. And that assessment of standards maturity needs to be considered, because some of this is new.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and this is Paul. I mean, I'm worried that we're sort of on a slippery slope on this thing. I mean, I agree it's important, I agree it's a high priority, it could have a huge impact. But because I think of that you still need to have some operational experience and what I like see in the NPRM, 2015 NPRM are things like the Unique Device Identifier, which has to be included in the C-CDA. That there are a lot of data elements in Unique Device Identifier and that technology has never been done before, never been done before in an electronic health record. And then you've got the issues of the HL7 implementation guide that hasn't been published yet and I just have real concerns about all of that stuff. And I don't want to be saying, well, that should be included, I'm saying, that stuff can't, should not be included in the transition of care update until there's some experience with it. If you include it, I'll tell you one thing, you're not going to get a transition of care document until well into 2016, at the earliest, and – because it's a lot of work. So I guess I'm only willing to go as far as to say that this is an important topic, it needs to have an important discussion and that whatever is decided should be decided for everybody. And I'm not willing to say, we need to support these new things that people like but have never actually used in operation.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay –

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

And this is Mike –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Don Rucker. I'd like to add in that I think when you look at transitions of care, some of the stuff gets into things like guidelines and temporal reasoning, right, because transition of care sort of implies a plan over time. But the granularity and the type of representation for time in these clinical things is an unsolved problem from an intellectual point of view. The CDAs to date have sort of gotten around that by being sort of a slice in time kind of thing, or looking at events in the past. But when you're looking at events in the future, that's planning, I mean, that's an area of active artificial intelligence research. I don't think we can put in things there into standards just right now. People have been working on that, by the way, for decades.

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

And this is Mike Lardieri. I think this sort of gets to our discussion from our last session where, and I totally agree with the Unique Device Identifier, because it's never been done before. But where you have like vocabularies that have been used, and we spoke about this last time, in behavioral health they've been using these vocabularies, they just haven't gotten into the CDA yet. But if there are already known vocabularies that are pretty standard in a sector that's already using them, they could be included and maybe not something that's brand new and sort of have to make that distinction.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I'm hearing I need to present this as there are some important nuances here, that there's – that the goal is the right goal, that consistency is critical, that there may have been extensive work development maturity within a sector to validate a standard based on the history in that subset of providers. And that there are other places where we feel like the standards are still in a development cycle, Don is suggesting it may be a very long time until we actually nail down care plans because of how they represent future time and coordinate planning across providers. It's not a trivial problem. And so we're – we want to surface sort of the dilemma here of, there is some emerging work, we'd like to encourage its adoption, but we also want to be cautious about overly prescribing things that are still immature.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

And –

Larry Wolf – Health IT Strategist – Kindred Healthcare

That's the balancing act I'm going to try and take.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

I think especially as we consider the, is there a distinction between all providers and some specific sort of verticals if you will, right, because I think part of the appeal of this in general is that it's sort of good for everyone, right. That there's sort of a global standard here, a true standard rather than sort of a lot of series of sort of smaller subsets of standards between selected parties that have no impact on lots of other transitions of care.

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

This is Mike, I'm not so sure it's that because I think if they just haven't been used extensively, an example would be housing, and knowing somebody's housing status in behavioral health we need that, we use that a lot. If a medical provider knew that a patient was homeless, I think that would make a difference to them, if they knew that. So that's the kind of thing I'm talking about, that you would want to share that, because if you're homeless, it's going to be real hard for you to comply with your diabetic care. So I'm not sure that it's just used in behavioral health, it's used across the board, but just used more in the behavioral health because we focus on it more.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Right, but are you going to ask for every transitions of care in America that – whether somebody is homeless, whether that status, that's an extraordinary cost if you're going to pull that out for every provider, for every transition of care for what is admittedly a very problematic group of patients. But ultimately, if you look at all transitions of care in America, the percentage that are folks who are homeless is very, very small. Now the spend in the system is probably higher than the percent, but it's still tiny.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

This is Carl –

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

I don't think home – I think housing status, and so housing status, I think yes, that would be something that no matter what place you are in the continuum of care, you should either identify what it is when it comes into you, and if the data's there send it. And if it gets sent, the other provider be able to receive it. If it's not there, they don't capture it, okay.

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

This is Liz, I just want to do a time check, because we have guests that are, I think, waiting to join us.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you Liz. I'm going to – I will do my best to present this based on what I'm hearing. Liz, you and I maybe can work on tweaking the wording that's on the slide a little bit.

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

Yup.

Paul Egerman – Businessman/Software Entrepreneur

Larry –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And Larry, this is Carl –

Paul Egerman – Businessman/Software Entrepreneur

I think you have to suggest that there's not a consensus on this issue. I think there's –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yup.

Paul Egerman – Businessman/Software Entrepreneur

– it just strikes me we could be talking about this for an hour –

Paul Egerman – Businessman/Software Entrepreneur

Yup, you're correct.

Paul Egerman – Businessman/Software Entrepreneur

– there's a lot of follow up.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I will highlight that piece.

Carl Dvorak – Chief Operating officer – EPIC Systems Corporation

And Larry, this is Carl, I need to drop off and I'll rejoin when I get to my car in the parking garage. But back on that issue, I think there's a larger issue and that is, sometimes the homeless status or the housing status might be a topic. And we somehow presume the benefits as if we mandated the collection of it was available to everyone and had the impact of pervasiveness. And if what we're really talking about is providing a place to transmit should someone collect it, I think we sometimes put forward the benefit case as though everyone universally collects it and then justify doing something that only a very, very, very small percent of the doctors and nurses would likely do. And even then, it's only for a very small percentage of patients that would have an actionable or direct benefit to. So I want to think about that with each one of these, because I see that pattern emerge, and I will rejoin in a couple of minutes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, thanks Carl. Okay, well let's turn to our guests.

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

Hello, Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think we have some separate slides for them, as well.

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

Oh, not for the Tiger Team.

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

Not for me, Larry. This is Deven.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Then let me zip back to the title – to the agenda slide, so that we at least have a clean screen for the web viewers. Thank you. So, take it away Deven.

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

Thank you, Larry. This is Deven McGraw from the Privacy & Security Tiger Team giving you all an update on what has been the streams of conversation on our end on the privacy and security aspects of the exchange of behavioral health data. And it's interesting, I jumped – I came on to the call about 1 p.m. so I was sort of in the middle of a thread of conversation that you all were having. But – so I'm not exactly sure what the topic was, but it's pretty – some of the underlying themes that I was hearing are frankly quite consistent with some of the discussions that we've had in the Tiger Team on DS4P, the Data Segmentation for Privacy standard.

So what we have done is sort of considered the sort of proposition that you would have – you enable the sharing from behavioral healthcare providers who are predominantly subject to federal law, requiring the patient's authorization to share data that potentially identifies or overtly identifies someone is receiving substance abuse treatment with providers who are not covered by that law. But nonetheless, the sharing of that information, even where the patient has authorized it, is then subject to additional redisclosure prohibitions. Meaning that the recipient couldn't redisclose that information without then also obtaining the consent of the patient. And so we heard from two of the vendors involved in the original pilot, including an effort that's actually been operational, although not for very long. So it's out of pilot stage and currently being utilized, but it hasn't been for that long.

And what we learned from the technology side is, and probably this is a repeat of what you all have already learned in your own discussions, is that what DS4P enables is the behavioral healthcare providers to actually be able to share the information with non-Part 2, Part 2 is the behavioral health set of rules, with non-Part 2 providers. Because it enables them to send a C-CDA with a restricted tag on it, that indicates that patient consent is required to further redisclose it. And what – if the recipient provider has the DS4P capability in their system, what they can do is read it. They can read that document or they can read the data element that's been tagged, but they can't consume that data or interdigitate or parse that data within the EHR because that's where you sort of get into trouble with respect to being able to control for redisclosure and making sure that only occurs with the consent of the patient. Because the data essentially is picked apart and inserted and used in software, and it sort of loses its capability to have that restricted flag on it. That's the piece that they haven't yet solved, it is a piece that they're working on, but right now what seems to be enabled, at least through the pilots, is the capability to just receive and read the document.

From a policy standpoint, we have also had some good discussions with the folks from the Substance Abuse and Mental Health Services Administration, SAMHSA. And what was interesting to us is that when this data comes in to a provider, and it's sourced from an entity that isn't covered by Part 2, so let's say the patient, for example, shares this data directly with the non-healthcare provider. Well from that point, it is not subject to the rules or constraints around redisclosure and in fact, that data could be entered into the EHR, parsed throughout the EHR system, consumed by it and able to be utilized in decision support software, for example, and then subsequently redisclosed.

We got into a discussion with SAMHSA about what would it mean to have the sort of patient reveal that data and they don't really – their guidance is sort of not quite up to date on how sort of this would be – how the DS4P, for example, technology would be handled from a policy standpoint. They did not like the idea that if you just, for example, printed it out – recipient provider prints it out, shows it to patients and patients verify that the information is correct. That that, in their mind, wasn't sufficient as a sort of authorization for redisclosure, But potentially talking through the patient, the sort of value of having this data in the EHR as part of the sort of recipient provider's treatment and explaining to the patient that from this point forward, the data will become part of our EHR. We can't necessarily always control how it will be redisclosed, but it is the best way that we can care for you, so we need your consent to do that. That's a piece that frankly, is probably going to be part of our recommendations to sort of urge SAMHSA to sort of consider the circumstances under which this data is coming in and how can you sort of honor redisclosure provisions, while also assuring good care for patients. And that seems to sort of be a piece that is a bit of an – it's not really sort of fully understood from a policy context, what the consequences of that will be.

So, just because I suspect you guys are out of time, you have a short time for your call anyway, I would say that where we're going to talk to the Policy Committee as you are on Tuesday and gather feedback on this. There are some folks on the Tiger Team who feel like it's important to enable the behavioral health data to at least be shared digitally with non-behavioral health providers and that DS4P is a promising start to that. But there are lots of concerns being expressed about what do providers do when they get this data? Is it possible for them to refuse to accept it, given that they may not be able to utilize their EHR fully with respect to this data? And they have concerns about good quality of care, can you create a sort of functionality present in EHRs but not require providers to use it and what are the consequences of that?

We have a number of questions that we still have on the technical side that we are asking the pilot vendors to address. And whether this is mature enough, and that's the theme I heard when I first jumped on the call, to be something that you would either encourage or require to be a capability in EHRs at the next iteration of certification is very much an open question. And one on which I don't think, and I'm speculating, but I think we would struggle to reach consensus on. I think there would be folks who would encourage it because this data's important to be shared and it's not being shared as robustly today as it should be versus whether we're sort of really ready to do this on a broad scale. So, that in a nutshell is – has been the sort of tenor of our discussion to date. Happy to answer any questions, but it just sounds from even the brief conversation that I joined with you earlier, that there may be a sort of similar set of trains of thought going with respect to your discussions as well.

Joe Heyman, MD – Whittier IPA

Larry, this is Joe.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

Joe Heyman, MD – Whittier IPA

I think that being left out of the entire discussion is health information exchanges. I mean, I have a health information exchange, we have a careful consent process that explains to the patient that any sensitive information that's available will be on the exchange and I don't even know if it's legal, but it just seems like we're discussing EMRs instead of health information exchanges.

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

So Joe, it's Deven. I'll tell you that we – not in this latest round of sort of investigation of this issue, but in our previous hearing that we did on sort of query response, HIE model, we heard some interesting testimony from Laura Adams up in Rhode Island, about sort of how they handle behavioral health data. And it's essentially a double consent process, because of the redisclosure requirements that attach to Part 2 data that frankly are not present in at least very many state laws, if any, that I have ever seen. But you essentially have the patients, they do their sort of overall consent to having the data in the HIE or accessible through the HIE initially. But that wouldn't be enough on Part 2, you have sort of a subsequent like, can this particular provider access it. But even when that provider has it, they still then would need to be able to handle that data consistent with honoring the redisclosure prohibitions, because they are supposed to follow the data through the chain. So even if we did talk about this at an HIE level, we would have to talk about it in terms of sort of how the individual systems would be able to handle this.

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

And Deven, this is Jennie. Going back to your presentation, which thank you very much, I appreciate hearing that. I just want to make sure I understood what you were just describing, which is that in the early pilot stage of implementation, it's possible to send documents that are tagged with a notation somehow that this document includes or contains this restricted data, meaning substance abuse data. However in terms of redisclosure, what's not being piloted yet, and perhaps there is no standard for yet, is being able to parse out from that document the restricted data.

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

Yes.

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

Thank you.

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

Yes.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I want to – Deven, this is Carl, I want to also clarify some things that I think are important there. I think it's too simplistic to think of it as receipt and redisclosure, I think how its incorporated, which caregivers have access to it, would that have been expected by the patients? And even things like how it might appear on a patient portal where another family member may have proxy access. So I want to be careful we don't underestimate the true extent of complications that arise from a perception of segmented data that a patient might have.

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

Well and absolutely, Carl, although certainly with respect to the DS4P implementation that I've seen, essentially that data can't be parsed, it can only be read. It couldn't be read at all if you didn't have the technology in place in your system.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay. That makes sense because –

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

But if – yeah.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

When you keep it in that simpler box, we might survive it.

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

Yeah. So you can re – sorry Carl, go ahead.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay, no, I'm fine, thank you.

Paul Egerman – Businessman/Software Entrepreneur

So Deven, this is Paul. I'll just make an observation. The way this has all been – one of the ways this was implemented in the paper world, before computer records, was that the substance abuse centers – groups were basically organized as separate, almost like sometimes group practices are clinics within a clinic, so they simply have their own medical records folders, separate from any other medical records folder.

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

Yup.

Paul Egerman – Businessman/Software Entrepreneur

And so patients would, in effect have two different folders and the data from one folder would not ever be able to somehow wander into – from the substance abuse side into the other side. And interested to think that the way you described the inability to consume the data, you actually have a model that's the same as the paper model right now.

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

Yes. Yes, Paul, although slightly more efficient transmission because you can send it in advance, you can take advantage of the transport protocols and have the document to the recipient provider in advance of care being provided. Not that that couldn't have happened in paper, but we know that it didn't necessarily happen efficiently or we probably would have never started down these roads, right. But the idea –

Paul Egerman – Businessman/Software Entrepreneur

(Indiscernible)

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

– that the, yeah – and I think for some people on the Tiger Team I think that's enough to start, right, at least we're getting the data moving from point A to point B. And probably what then would need to happen is the receiving provider would need to have a conversation with the patient about appropriate care and what happens to that information. And are you – can we use it in our EHR, populate your portal with it, etcetera, etcetera, all the issues that Carl and others have raised. And what was unclear to us from SAMHSA is whether that would sort of be sufficient, in terms of sort of meeting the redisclosure obligations. And so one sort of obvious recommendation that might come out of that is, we need some guidance on how this will happen in a way that the regulators deem to be in compliance with the law – threshold matter.

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

Yeah.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Don Rucker –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Deven, in the model that was discussed, I didn't track it all in great detail, but one of the concern areas that people talked about along the way was the liability aspects for provider, that they'd have to be signaled that there is something sensitive and make sure that they went and independently reviewed it each time. Because it wouldn't be on their medication list or problem list possibly or other factors.

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

Yeah.

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

Um hmm.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I assume that's still persistent in the model, right, everyone is alerted to the fact sensitive data exists and then they'd have to practically go review it each time, or make a mark that they've seen the latest that came in. That was part of the plan, right?

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

Yeah, this is Mike –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Don –

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

The problem with the Part 2, like Deven was identifying, when the provider has to talk to the patient about resending it, they have to know who they're going to resend it to, so that the patient says, yes it's that provider. That's what makes Part 2 so difficult in the HIE environment, because many people we don't know who is going to get it down the road.

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

Yeah.

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

Any provider involved in my care, that's coordinating my care I want to get it, but Part 2 makes me identify that even way before I even know who it's going to be.

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

Yeah, yup, yes.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

This is Don Rucker, I have –

Paul Egerman – Businessman/Software Entrepreneur

It's also a difficult situation in terms of getting the patient's consent or approval, if you have a patient who is in an acute care facility and needs to move to an extended care facility. Well, by definition the patient is ill and it would seem to me that there might be some concern about their consent being produced as a condition of getting care, which might be coercive.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

It's a complicated issue.

Joe Heyman, MD – Whittier IPA

I think also –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

This is Don –

Joe Heyman, MD – Whittier IPA

This is Joe, it goes beyond behavioral health, I mean, the situation that John Derr just men, I think that was John or Mike, mentioned about having to consent for stuff before it actually happens, that's the case with all of health information exchange. You're always consenting for information to be included that's – it can be sensitive without it being behavioral health information, and you're always consenting in advance.

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

Yeah.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Don Rucker. That was a great presentation. I share some of these thoughts. I think first of all there's a whole group of people who are never really going to be able to give an informed consent, so what you do with those unfortunate folks. The other issue is, the discussion has a little bit of a flavor of where the focus has been on otherwise functioning people with sort of isolated psychiatric illness. My concern is with patients who are deeply psychotic who are seen in the ER with hundreds of visits potentially, and where every part of their record is sort of a mix of their psychiatric and their non-psychiatric illness, they may be on 3, 4, 5 psychiatric meds, maybe 2, 3, 4, 5 "non-psych meds."

And it reminds me a little bit of the old HIV privacy discussion where, yeah, you can hide the HIV result, but if you see a CD4 count that's only used for patients with HIV, you sort of have it. So, I would just throw out that you're putting for the really sick people, this discussion and these policies essentially effectively box them into not having an EMR, because I don't think you can separate it out in the kinds of people we're seeing in emergency care and I think a lot of the other psychiatry settings. I mean, I'm just concerned about that we're not – that SAMHSA needs to have some other approach to this, and maybe it's even a court order. I don't know what it is, but these policies are going to redact so much information that we're going to be left without the records for the people who most need the EMR.

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

Yeah, this is Mike. We in the behavioral health community feel the same way, so we're trying to work with SAMHSA and suggesting and recommending that the General Counsel come up with some different sub-regulatory guidance –

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

Um hmm.

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

– to let the information flow better, and there are some recommendations with SAMHSA from the behavioral health community. Because you're exactly right, there's no way that these patients would be able to get the same level of quality of care that anyone else gets, just because of their condition.

Paul Egerman – Businessman/Software Entrepreneur

So this is Paul, it's an interesting discussion and I don't know if this is helpful – Deven, but listen to what Mike just said. And one idea might be to look at the issue of what is the definition of a redisclosure and are there categories or classifications or situations where the redisclosure limits should not apply.

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

Ah, that's a very interesting line of thinking. I –

Paul Egerman – Businessman/Software Entrepreneur

(Indiscernible)

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

– we could suggest that as part of our recommendation that's a fruit – potentially a be a – avenue for SAMHSA.

Paul Egerman – Businessman/Software Entrepreneur

– because that might be a way to respond.

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

Yup.

Paul Egerman – Businessman/Software Entrepreneur

That might be a way to respond to what Mike just said.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

And it also might –

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

I'm just thinking, shades of accounting of disclosure.

Paul Egerman – Businessman/Software Entrepreneur

– help a lot of people.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

That's exactly what I was thinking, the acc – the way we solved the accounting of disclosure was we redefined the situation under which you had to do it. So I'm suggesting the same thing, can you redefine what a redisclosure is in a way that that sort of makes this whole issue a lot easier.

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

It really can also –

Paul Egerman – Businessman/Software Entrepreneur

It goes back to basics saying we can treat the patient, right, and we do the right thing for the patient. And so, that's just a suggestion.

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

It also, another suggestion that's been made, it also really gets to the "to whom" section and what we found, because I ran the project with Laura Adams and –

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

Yup.

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

– four other HIEs and when they did their focus groups, most all the patients in the focus groups they said fine, share my information –

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

Yup.

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

– with providers who are involved in my care.

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

Yeah.

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

And right now that “providers who are involved in my care” is not an acceptable reference in the “to whom” section, or it’s not being interpreted as that is an acceptable reference. But providers – I mean, patients are fine with that if it’s a provider involved in their care and if they don’t want, then they – really, they can’t participate in the HIE, but those that don’t want, are less than 10% of all the people –

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

Yup.

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

– that were in the focus group. So that’s also another way to open that up.

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

Yes, yes it is.

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

This is Liz, I just want to be sensitive to time, because we have some other speakers that are going to be joining.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

We should be thoughtful though that just because 10% of those behavioral health patients who presented for focus groups said they wouldn’t like it, I’m not sure that extrapolates to those behavioral health patients who chose to remain private and not come to focus groups. So, I do think we have to be thoughtful about that, that silent section that may, in fact, still have a problem.

Joe Heyman, MD – Whittier IPA

And also – this is Joe. Even if it is only 10%, we also have to protect that 10%.

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

Yeah. Yes, yes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So not to minimize those 10%, but addressed to 90%, I think introducing this concept of providers who are involved in my care would be a very interesting thing to bring forward to SAMHSA.

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

Yeah.

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

Right, in fact, that’s been presented and we encourage other folks to also present it some more.

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

It sounds like we need to add – we might need to add our voices to the chorus, Mike.

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

Sounds good.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, well Deven, thank you very much for the update.

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

Thanks, Larry. Thanks to all of you, we’ll see you on Tuesday.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, and you can tell there’s going to be lively discussion on Tuesday as well.

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

Yeah. Take care, everyone.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so are we ready for the quality measures group to talk to us.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Hi, this is Terry. We do have a slide deck and I don't know that Helen's on.

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

This is Helen Burstin, I'm on, too.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay. Helen, do you want me to go through the deck?

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Please, yup, that's good.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Hey, it's Kevin, I'm here, too if you need.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay great. So I am cognizant that your call ends in 22 minutes and we have 20 slides. So I am going to go fast and I realize you didn't get these slides until this morning, but I just want to give us some time to discuss. Next slide. So the Quality Measure – the HIT Quality Measures Workgroup was tasked by your workgroup to look at clinical quality measure as they related to the long-term care and behavioral health CQM opportunities for voluntary EHR certification. Next slide.

So in order to facilitate that we held two calls, one for each setting, and you see here on slide 2, if you're following not on the live meeting, who was invited to these calls. So we had representatives from the communities at large as well as from the federal community. We used the federal agency representatives to help inform our questions that we were asked and the framing of what we looked at. Next slide.

So the asks that we looked at were to identify infrastructure needed to support quality measurement in long-term care and what are the foundational capabilities, minimum functions of EHR systems in these settings. Then you can substitute behavioral health for long-term care. The second one is certification of minimal data elements or assessment tools that are needed where there are standards for the data elements. And throughout this presentation what you're going to see repeatedly is data element standard, how critical that is. And then finally the gaps that need to be addressed or barriers that needed to be removed to support electronic quality measurement construction and reporting. Next slide.

So the next slide indicates future vision for quality management that's really focused on, will voluntary EHR certification help drive step-wise progress towards achieving the vision. And here you just see there's alignment of the key data elements, expansion to a larger data – data set and once again, just kind of follow up on your last dialogue, this role of interoperability for exchange of information across the care settings with these results that are listed there. Next slide, so now we're on slide 5.

So what is the value for this? Why is it important? CMS, states and payers have a – could potentially have a certification platform that could provide the foundation for quality measurement, starting with the data elements; once again, we'll talk about that. And the assessments that are of most value and go to where there are already some standards related efforts. So our goal, part of this was to look at what is – how can we poise ourselves out there to look for voluntary certification in a way that people may embrace. So in a sense, what's the low hanging fruit out there, and as you'll see, we actually started with a slide that you guys had presented previously, so starting with the sub-settings, long-term care and behavioral health. Next slide.

And then the next slide really looks at building on the transitions of care, and that was already dialogued about today on your call, how difficult transitions of care is really, in some ways, this continuum of care, this care management. Because so much is in the past, present and future, so you have a time element there, but that's an important building block to move towards sharing information, once again, interoperability between the settings. And the recognition that efforts toward quality measurement needed to consider using the platforms that were out there that support the ability to share information. So next slide.

So we were tasked to look at both the long-term care community as well as behavioral health. And what we wanted you to recognize, and I think your committee already knows this is that these two communities are starting at different points. And you're going to see that in the recommendations as we go through that long-term care has been significantly influenced by CMS, the standardized assessment data that have been required to be reported by long-term care in to CMS. The measures that are then calculated from the data that has been submitted and the potential focus on standardizing these data elements, developing consistent data elements that are cross-walked into recognized standards from the ONC standards group. And then looking at consistent assessment. So really this whole concept of semantic interoperability, you'll see becomes really important here.

Finally that behavioral health settings are a little different in that we could not find evidence that there had been traditional reporting of quality measures to external bodies, a la CMS. There probably is some of this going on, but we did not get a sense at all that the extent of that is consistent with what is going on in the long-term care community. And that the work to date, as you'll see here, has not occurred in a standardized way in that community. So let's go – the next part we're going to look at is really what happens with the long-term care findings. And you can go to the next slide, there.

What you'll see – this is a slide from you guys, is the adoption rates for long-term care providers, and you can see that there are adoption rates of uncertified "EHRs," remember, there aren't certified EHRs, which is why they're uncertified. And you can see really you from 4% in inpatient rehab up to 43% for home health agencies, as well as hospice. And we're going to show you and remind you, because that is your data, the difference between this and behavioral health community. So, let's go to the slide.

So I think the one thing that slide 9 points out is that there is potential for there being some framework to work from, because in some of these agencies we have 43% reporting of adoption rates. In addition, we know that there is a huge delta between, for instance the hospice situations and the inpatient rehab units. We relied on your data for this, so we didn't re-look at it, but there is that large discrepancy. But what we wanted to focus on was, what should the EHRs support. And what we know is that we believe that they should report – support this common definitions for data elements. Remember, many of these providers or facilities are already reporting data sets to CMS that are used for evaluation for them.

So what our emphasis was on was really looking at, are there common definitions for data elements from the assessment tools that could be used across care settings, so really moving to the standardization of elements. We received feedback during our meeting that people were supportive of this, that there has not been, from what we could tell, a concerted effort to look at the semantic interoperability of the data elements. What we know is that there are defined data elements that are supported, they may or may not be mapped to ICD-9, 10, SNOMED. They may or may not be mapped to another data assessment tool that's being used, even though they may be theoretically at least, looking at similar data capture. And that the work to standardize some of these elements within the rubric of long-term care, as well as then to map them to standardized vocabularies that have been endorsed and/or still need to be endorsed, would be critical. If that happened, then the data elements from the assessment tools obviously could be collected more seamlessly and that there would be this electronic transitions of care document, because remember these are long-term care centers, so people are going in, obviously some are coming out, and across the transition of care.

So the next slide looks at what we came up with for a recommendation for voluntary certification. And this was really the goal from you guys, that there be a long-term data submission module that could be certified that it would obviously require a lot more work than we were able to do. Because it would need to include what are the specific data elements that need to be collected, mapped, focusing on a small number of high value measure domains that we know have already been mapped and/or worked in some of the other clinical quality measures that have been endorsed. And then the – so the elements and then how to collect and send them in in an operable way. We also recommended that CMS consider certifying their free CMS patient assessment tool to perform this function. So CMS has not done that, CMS was on these calls and seemed to be supportive of these ideas, but obviously the people we were talking with don't speak for CMS at large.

The next slide goes into just some other considerations and barriers that we believed there was probably a need for a new eCQM for the timely electronic exchange of interoperable transitions of care documents and you guys were actually just talking about that. That ONC should consider current specifications and requirements of the CMS long-term care program, is they were going to develop – if ONC was going to develop EHR certification. And then finally, what we've already talked about, and you're going to see embedded in all of this is this harmonization of different data elements with the C-CDA and other standards already established for MU. That would require significant work, once again, because the versioning of the data elements is obviously dependent upon the mapping of the data elements and/or the identification of the standards to be used for those data elements.

So with that we're now going to quickly go into behavioral health. Once again, I remind you that we had one meeting with the behavioral health people and their names are listed earlier in the slide deck. We did work closely, once again, with the federal people to help to identify for us what would be the questions that we should ask. So the next slide should be familiar to you, because it's your slide. And I remember I was shocked when I saw this slide that psychiatric hospitals are 2% to 2-21%, some at 65%. So once again you see this huge delta. This seems to be a little deeper where the minimum start is compared to long-term care, but you see a continuum of embracing of uncertified electronic health records, remember, uncertified because there isn't one yet certified. Next slide.

So what we did here was we really looked at what were the clinical quality measures that might already be out there that could potentially drive the response to your questions, which was related to once again, what quality measures should we be looking at in this domain. And what we're going to see is that there are some clinical quality measure that are relevant, just as – like there probably are in long-term care, for instance, pneumococcal vaccinations. And then there's once again this opportunity to align data elements. Next slide.

So, what we was we pulled out eMeasures that are either in MU2 or in development, and you see a fairly broad list of them here. And I know that you're familiar with the vast amount of these, depression, alcohol screening, medication management, obviously that's pertinent to your discussion earlier, too, where we talked about people that may have behavioral health medications as well as, for instance, diabetic medications. Then we went into pediatric arena, because we had identified eMeasures in MU2 or once again in development, that would be pertinent to the pediatric population. Next slide.

So, the eMeasures for adult mental health you see here, the highlighted ones are currently in MU2, the others are developmental measures that have been proposed through the Health IT Policy Committee for potential inclusion as clinical quality measures. And I'll just let you look at this afterwards. Next slide. And this is similar, once again, but it's for pediatric mental health. Obviously there are less pediatric mental health, behavioral health measures identified, but you can see that there's – that many of them are in draft as we move forward. Next slide.

So the recommendations for behavioral health voluntary certification are a little different than they are for long-term care. We believe that because there's been so much work in measurement, even though they're not externally reported, it's probable, I use that word intentionally, that the behavioral health providers are looking at some of this data. We believe they're probably doing that just because of clinical quality or anything like that. So the potential exists that if they were using a Health IT system, I remind you of that data that shows a large gap between what may be being used in certain settings, and not in others, that you could certify the Health IT system to have the functionality collect, send a small set of the common data elements. You could certify to have the functionality to collect and send a small number of the measures, so the elements, then to the measures. Or you could certify to send a small set of key patient assessments or you could elect to do one, two or three.

I think what we believe is that, though we did not have the time to do this, is because there are clinical quality measures out there for behavioral health, that the work to map those data elements into a standard has probably occurred, once again, probably. But it may be that that isn't true, you really need to start once again whereas where we believe in long-term care. So if we compare this to long-term care, what we know is long-term care, they're sending data, they're sending assessments, but we don't believe the vast majority of those data elements have been mapped anywhere. In behavioral health, the odds are that if they're running any kind of Health IT system, they're collecting the data elements, but they may not be sending measures or key patient assessments out. Next slide.

Once again, and this follows up just aligns totally with the discussion you guys were just having about behavioral health CFR 42 Part 2, the indications of that concerning – concerns remain about data privacy. So for instance, if we go to looking at a small set of key patient assessments, we can hit patient privacy fairly quickly, probably in all of this we do to some extent, depending upon the setting where the data is being collected and/or patient consents. We were fairly loudly reminded by the experts on our call that without incentives, voluntary certification would probably not happen. We did not have that same echo on the long-term call, and that may be just because long-term care is already reporting to CMS, having tools developed for them to expedite their reporting might just make it more likely that there would be uptake. But from the behavioral health community, we heard loudly that without incentives, there would be little – and these are fiscal incentives or some tangible incentive, voluntary certification would have low uptake.

That once again there's this need for central organization stewardship of behavior – for the stewardship of the measure development. That specialized clinical registries, we did hear this repeatedly, that they – it would be very helpful for them to be part of the Health IT system. I think this is predominantly in facilities that are providing primary and/or specialized care as well as behavioral health, the ability to pull those patients into a population-based registry and work with that. And you guys talked about this earlier when you talked about homelessness and housing that the non-traditional determinants of health should be available and incorporated into the Health IT system with endorsed standards. And you see – that there.

So the next slide is the last slide. And what we believe is that this discussion could really inform the broader framework for certification around quality measurement for other settings. So while we focused predominantly on just behavioral health and long-term care, I think that there are lessons learned here, data, data specifications, data vocabulary, semantic harmonization, aggregation of data that obviously apply to any other specific, in a sense one off setting that you want to look at. There are sort of commonalities that could be applied. The current state of Health IT adoption should guide the pathway. And then once again, the role of incentives may be different, depending upon what your starting point is, so if you have uptake, you have already been reporting, you have somebody that's looking at your reports, like CMS, your uptake may go more rapidly than an arena where that hasn't happened.

And with that, I'm going to stop and turn it over to Helen. Helen, I don't know if you have any comments or Kevin – Kevin supported us a lot through this work, so, you guys would like to add before we turn it back.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

This is Kevin, nothing from me.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Helen, anything or – okay, we turn it over to your committee. Hopefully – we did only have a few meetings about this, we were trying to get it done before next week. So hopefully we addressed what your concerns were.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

This is Carl. One comment that perked me up in there, and I could hear both comment trains going on at the same time, with regard to incentives and its relationship to adoption as compared to certification and its relationship to adoption. I want to make sure that we truly understand the feedback that incentives are probably what drives adoption, certification in and of itself, I think that was the first posited under Secretary Thompson's HHS administration or David Brammer, and it turned out certification did not really drive adoption.

So I would want to be very careful that if we're encumbering the – of industry with certification, which increases costs, we could actually drive adoption lower or restrain adoption by accident if what we did was simply increase the cost of the products that would otherwise serve that industry. So I do think we need to take that incentive discussion very, very seriously and second we be very careful we don't create an adverse impact on adoption by increasing costs of products, which is a natural outcome of certification.

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

Yeah this is Mike –

Larry Wolf – Health IT Strategist – Kindred Healthcare

So its Larry, I wanted to get in the – sort of the existence proof. We do have examples of the LTPAC providers getting modular or even complete certification, I think, in one case, even though it's not mandated in their space, they felt it was significant to their customer base to say that we can do functions at a level at which the acute care providers – the acute care vendors can also do them. So there are –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I respect that also, but I think the real question is, does it drive adoption into the user base in any measurable way and that, I realize a lot these will be cross-over vendors that will seek certifications to create a competitive differentiation, but we really are needing to think about the adoption into the end user target space, right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah. No, I agree with you about the adoption piece, I didn't want to ignore the fact that we do have vendors who, on their own, have gotten certification.

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

And this is Mike.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

And Larry, would support that, this is Terry, is that we just took your slides, so we don't know – you probably have a lot more information than we do – I obviously do about why you see high adoption in some and not others.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, and the adoption – I agree, the adoption rates – the reported adoption rates really suffer from lack of a good measurement tool as well.

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

And this is Mike. I would agree with that, and thanks for the presentation, helpful and agree with most of it. Some of the background on behavioral health is most behavioral health providers, except for psychiatric hospitals, psychiatric hospitals do report to CMS, but they only report about 5 measures to CMS.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
Right.

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

The rest of the behavioral health providers for the most part, if you're talking about behavioral health clinics, which treat the seriously mentally ill, they're reporting to Medicaid, so that's never getting up to CMS. But they are using those measures. And the other thing we need to look at, as we move forward, if behavioral health is going to participate with ACOs, patient-centered healthcare homes, they're going to be using these measures.

And there are now 15 behavioral health measures under Meaningful Use Stage 2 and we just approved another 12, I believe, under NQF that I would suppose will get implanted for Stage 3. So there are enough behavioral health measures, but if we're going to play and share information and be on the same shared savings platforms, we have to be able to collect and report on those measures. And to the issue of does certification drive adoption, I agree, it doesn't the incentives don't but those pieces of certification that are important for transitions of care and sharing – I don't know how to say it, sharing shared measures across a system if you're in a shared savings situation, are going to be important. Because otherwise nobody will play with behavioral health, I mean, why would I play with you if you're not going to help me get my shared savings around this, and we can communicate around that. So those things are going to be important going forward.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

This is Kevin Larsen, I'll make a quick clarification. Numbers of measures on the list that were shown to you are actually Medicaid's set and also in the CHPRA core set. So the measures for behavioral health in the Meaningful Use program, many have been built and directed by the Medicaid Program.

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

Right. Um hmm.

Joe Heyman, MD – Whittier IPA

And this is Joe, I'm an outlier, I know I'm an outlier, but I think that using an EMR to collect measure information is putting too much of a burden on an EMR. And that third parties who need that information should have other applications that collect the information from the database.

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

And Joe, this is Mike, I'm not against that at all, and I don't mind if it comes from a third party, I just think that having the capability to collect and report the measures somehow is important. And so yeah, I don't have any problem if its outside of the EHR but you have to be able to do it.

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, I'm sure we could continue on this for a long time, but we're now at the top of the hour. Any burning comments before we go to public comment? Thank you very much, it was a great presentation, you did an amazing job crunching the slides into the time we gave you. We should be in good shape to do the same thing with the Policy Committee next week. I'm sure there will be lots of discussion there.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Thank you.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Thanks Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Appreciate the effort you guys have taken.

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

And can we share these slides, I don't think I saw them, this is Mike. Or if you did, could you send them out again.

Larry Wolf – Health IT Strategist – Kindred Healthcare

They should have been sent out, there were two batches of slides sent this morning, Mike.

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

Okay, maybe I just missed it so far. Okay, thank you.

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

You ready Larry?

Larry Wolf – Health IT Strategist – Kindred Healthcare

I'm ready, let's go to public comment.

Public Comment

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

Okay. Operator, can you please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

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

Thanks everyone.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. I'd like to thank everybody for their efforts today. Michelle, it sounds like you, Liz and I have a little bit of editing to do to get these slides ready for next week. And look forward to the discussion at the Policy Committee.

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

Sounds good.