

**HIT Policy Committee
Certification/Adoption Workgroup
Transcript
February 14, 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/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

Hi, Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Good afternoon.

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

Carl Dvorak?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Here.

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

Donald Rucker?

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

Here.

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

Liz Johnson?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Here.

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

Hi, Liz.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Hey.

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

George Hripcsak? Jennie Harvell? Joan Ash? John Derr?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator 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. Marc Probst? Marty Rice? Maureen Boyle?

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

Here.

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

Hi, Maureen. 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

Hi, Mike. Paul Egerman?

M

Hello.

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

Paul Tang? Stan Huff?

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

Here.

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

Hi, Stan. I'm sorry, do we have Paul Egerman? Thank you. And Liz Palena-Hall from ONC?

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

Jennifer Frazier from ONC?

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

Here.

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

Hey, Jen. Elise Anthony from ONC?

Elise Anthony – Senior Policy Advisor for Meaningful Use – 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

Hi, Elise. Are there any other ONC staff members on the line?

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

Judy Murphy's on the line. I can just be on until the top of the hour.

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

Thanks, Judy. And with that, I think I'll turn it back to you Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well, I'd like to welcome everybody back. We are nearing the end of our review of the information we learned at the behavioral health hearing a couple of weeks ago, well now more than a couple of weeks ago. And then we should be – hopefully we'll make it through that today. I think we're actually in pretty good shape to do that and then we'll take a look at next steps, specifically starting to pull this together into a set of overall recommendations for both long-term post-acute care and behavioral health. I think that's about it for today, so, let's move on.

So, a reminder of our timeline here, so we're at the end of the block of the behavioral health materials. We've got a call next Friday to start the review cycle, looking broadly across everything we have. And I think we'll need a second meeting, so there should be some material coming out from Altarum to get that scheduled. And then just before we talk to the Policy Committee, we're going to hear from one of our sub-workgroups on occupational classification as part of expected Federal Register announcement from the Department of Labor, looking for – I guess it's actually going to be like a 2016 or 2018 update, but they're going to want input this spring. So, I think that's it for our timeline. Oh, there's one other piece, one other piece. There's also going to be a presentation to the Health IT Standards Committee a week or two after we report to Policy, so, we probably should add that to our work plan, guys.

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

Larry, this is Michelle.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

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

We might want to think about after March, so typically when we present to the Policy Committee, we present draft recommendations and they usually come back and ask you to refine them. Maybe they'll get accepted first time through, but if not, you'll probably have plan for meetings between March and April.

Larry Wolf – Health IT Strategist – Kindred Healthcare

That's probably true. I expect there will be feedback from the full committee.

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

You never know.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I would be shocked if they said, you guys are brilliant, you're done. But maybe, you never know. So let's move ahead with today's work. Next slide please, and maybe Jennifer, you could continue walking us through these?

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

Sure, all right. As we've heard, the majority of ineligibles, speaking for health providers, do not have prescribing authority; however, psychiatrists, psychiatric nurse practitioners and psychologists in some settings are prescribers. And while this functionality is not core across behavioral health providers, behavioral health organizations a prescriber module could be useful in this diverse setting. Behavioral health organizations providing integrated care will also need medication related functionality in their EHRs. We've proposed the following areas for behavioral health certification: To support the ability for a user to electronically create and transmit prescriptions and prescription-related information, to support the ability to automatically and electronically track whether a drug formulary exists for a given patient or medication. Support the ability to enable drug-drug and drug allergy interaction checks and support for eMAR, which is electronic medication administrative record.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so I'll jump in with some conversation here. So, it's Larry, and so we heard from the hearing in our subsequent discussions, that there's a mix of providers, some are covered in the existing program as eligible professionals and are already potentially buying systems that meet the criteria here and are using them to write prescriptions. But we also have other folks who could be prescribers, who are not in the eligible program, who might be needing to write scripts and we have folks in these care settings who might be administering meds and also there might be value to some of the clinicians in knowing what the current meds are, so it's sort of interesting. Isn't there a certification criteria for medication list? Does that sound right?

Joseph M. Heyman, MD – Whittier IPA

Larry, this is Joe, can I just ask a question?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sure.

Joseph M. Heyman, MD – Whittier IPA

If there are already psychiatrists who are certifying for Meaningful Use –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Umm hmm.

Joseph M. Heyman, MD – Whittier IPA

– that would imply that there's already something out there that they're using to certify for Meaningful Use –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Joseph M. Heyman, MD – Whittier IPA

– that's certified, I mean, that's accredited. They're not certifying for Meaningful Use, they're attesting for Meaningful Use, but there must be something out there that's already certified that does exactly what we're suggesting here, that we're going to make for voluntary things. And I'm just wondering if that's already available, why would it be necessary to have some sort of additional thing?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right, so I think this is in keeping with the theme that we've got really throughout this that pretty much everything, not pretty much, almost – with only a couple of very focused exceptions, all of this is building on the existing 2014 criteria. And so to your point, all of this is out there already and so I think we're specifically highlighting areas that may be of particular value in this setting or where – in this case, where the mix of providers would say that some providers had value for this criteria and others don't. Am I answering your question or –

Joseph M. Heyman, MD – Whittier IPA

Yeah, I guess so. I guess what I'm thinking is that in general, if a psychiatric nurse practitioner or a psychologist who can prescribe, it would seem to me that they'd be purchasing software that's already available and certified.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

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

This is Mike Lardieri. I think the only problem with that is that there aren't that many that are just certified for ePrescribing, to my knowledge. And it might open up the marketplace a little bit for those prescribers if you had a voluntary module on this.

Joseph M. Heyman, MD – Whittier IPA

Well there are separate ePrescribing programs that you just use over the Internet, you don't even – you're not – you're just a subscriber to it.

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

Umm hmm.

Joseph M. Heyman, MD – Whittier IPA

And those are available now and those are definitely certified, an example would be DrFirst.

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

Yeah, I'm familiar with that one. Yup. Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I think the theme here though is, we've got evidence that in fact these are things people are doing across the board, and as you're pointing out, even in these care settings, people are probably already using – those who are prescribers, are likely already using a system that has an ePrescribing module. So what we're doing here is just identifying in fact, that that's the case, that there are some providers – behavioral health providers, for whom ePrescribing is important and there are existing criteria that seem to be sufficient to meet that need. And therefore there would value in having a – if we're creating a behavioral health grouping, that including this in there makes sense for some providers.

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

This is Jennie, I would agree with that.

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

This is Maureen, I do as well.

Joseph M. Heyman, MD – Whittier IPA

I guess I'm confused because I don't understand. If the programs are already out there and already certified, why do we need to have a separate category for behavioral health? It just doesn't – I mean, first of all, there are modules out there that are already certified and second of all, there are actually behavioral health EMRs that are out there that do this that are certified. So I'm just confused as to why we're creating a special kind of category for behavioral health.

(Several speakers talking over one another)

Joseph M. Heyman, MD – Whittier IPA

But I'm not going to die on my sword over this, I mean, it's not worth having a lengthy conversation. I just will register my misunderstanding.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well, we'll get a chance to revisit that when we do our wrap-up Joe, because I think that gets to really the charge from ONC –

Joseph M. Heyman, MD – Whittier IPA

Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– about – program and we should highlight those differing opinions on the workgroup.

Joseph M. Heyman, MD – Whittier IPA

Okay, whatever.

Larry Wolf – Health IT Strategist – Kindred Healthcare

About there already being plenty in place or there being value in further extending.

Joseph M. Heyman, MD – Whittier IPA

Righto, okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

You okay?

Joseph M. Heyman, MD – Whittier IPA

Yes sir.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Great.

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

And Larry, this is Sue. You had asked about a medication list and yes, there is a requirement about medication list, but it actually got grouped probably under transitions of care summary –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Ahh.

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

– because they put the problem list, the med list, the med allergy list all bundled under that umbrella.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. Thank you for helping me understand the grouping of these. Any other comments about this set of recommendations? So, we should probably follow our new protocol and run through the workgroup and see where people are about putting forward these areas for certification.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Are you looking for a vote Larry?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yes. Thank you.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, I'm good with that.

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

Yeah this is Mike, I'm good with it.

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

This is Maureen, I am as well.

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

This is John Derr, I am as well. I thought silence meant we all said okay, but –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, we can do that.

Joseph M. Heyman, MD – Whittier IPA

Well this is Joe and I won't be silent and I'll tell you that I don't understand the need for it since it's already out there, so I don't agree with pushing this as some extra needed thing.

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

This is Jennie, I agree with the recommendation.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

This is Carl, I think that items are reasonable items, I again, like Joe, question the utility of having it be a special thing.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

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

This is Stan, I agree with the recommendation as well.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thanks. Maybe we should take John's suggestion and look for dissent, although I appreciate the affirming comments. So if we're good, let's move on to CPOE.

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

Okay, on CPOE. So again we heard the majority of ineligible behavioral health providers do not have prescribing authority; however, some are prescribers and this functionality could be useful. Ineligible behavioral health providers typically do not rely on labs or radiology; however, there are some eligible behavioral health providers and ineligibles who capture a lab test for urinalysis and other purposes. So the proposed areas for certification would be to support the ability to electronically record, change, and access the following order types: Medications, laboratory; radiology and imaging.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So this is extending the order piece we just looked at and it's not just meds here, right, this would be all orders and you're specifically pointing out that there are some labs and other things that do get ordered.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Can I ask a question? This is Carl

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Is this envisioned to be optional and/or modular in some way? I'm not an expert on behavioral health but we do have sites that do behavioral health. But given the premise that the majority don't prescribe and the second premise that the majority don't use labs, if we make these requirements of being behavioral health certified, aren't we fundamentally just adding ultimately cost and complexity to products –

Joseph M. Heyman, MD – Whittier IPA

Thank you Carl.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

– with features that we acknowledge aren't necessary in general? And I wonder if at least some sort of recognition of how to tackle that so we don't add cost and burden where it's not actually – where it's recognized to not be all that useful.

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

So this –

Joseph M. Heyman, MD – Whittier IPA

Yeah, so Carl, my sense is that within – go ahead, it sounded like someone else wanted to jump in.

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

Sorry, I was just – this is Maureen from SAMHSA. And yes, that – the premise is that we would have a modular program to meet the diverse needs of different types of behavioral health providers. So you're right, if we did do – if we were trying to go after something that's core to behavioral health, these ones that we've been highlighting as only relevant to a subset of providers would not – we wouldn't recommend including them in that core.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And with regard to certification, do we – obviously there's the incentive side of life that may not be available to these folks, so that would leave the assurance side of certification, you know what you're buying and maybe more importantly, payment considerations if you don't use something certified. If a practitioner uses lab tests in a useful way once or twice a month, would they not be eligible for certain programs if they did that outside of a certified application that did labs? Is there a penalty side here that we should be especially cautious of or payment opportunities that they won't be entitled to participate with because they won't – they'd either have to pay for a more expensive, certified, all-encompassing EMR or they have to skip out of certain programs that would ultimately have that written in as a requirement? Or do you think the programs will go down to specific modular requirements? Although I still worry about the occasional use and the true value in the penalties that are associated with that and whether or not the once a month lab guy is going to be compelled, because he won't be able to participate in the program at all, even if it doesn't require labs that often.

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

This is Maureen – sorry, I was just going to say, from the SAMHSA perspective, I think we've talked about how we intend to, through our grant program, incentivize the adoption of certified EHR technology and kind of building off of this program, depending on what it looks like. So that – with the intention of not forcing behavioral health providers to get a Meaningful Use certified EHR, but to kind of focus down on the components that are really necessary for those programs. And – but how that's going to look is going to depend on the program that comes out of this, but the intention is to, exactly like you're saying, to try and stop forcing them to pay for functionality that they're not going to be using.

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

Hi, this is Elise from ONC and just to echo that point for Maureen, from ONCs perspective we're very interested generally in the modular approach, which provides more flexibility to vendors and ultimately to providers. And I think this here would be no different, the benefit here being for those BH providers who are using an MU system, those in fact, probably do have more requirements than what they may need. The goal with this kind of effort is to examine how we can – we of ONC can be more strategic in sort of directing the specific needs of BH and as earlier discussed, LTPAC. So the modular examination that the workgroup is going through would help with that initiative.

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

This is Jennie and just to build on both what Maureen and Elise just said is that I think a corollary to providing flexibility to providers and vendors, I think this modular approach also provides flexibility to federal payers and programs implementing various demonstration programs to target the components. The modules, that they would want to emphasize or highlight in a particular program.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah, it helps to know the purpose, if we're crafting a club it's one thing, if we're crafting a basket of candy to entice people to come along with us, that's a different thing. So, I was more curious in terms of what – will this be used to deny people payment because they didn't use a certified system to look at the three labs a month that they actually used in their practice. When in fact, a paper fax would have been just fine for what they needed for those three labs.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So Carl, do you have a – sorry –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Go ahead.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Carl, did you have something particular in mind that you think that – where you think that might happen.

Joseph M. Heyman, MD – Whittier IPA

Well, this is Joe, didn't that sort of happen with Meaningful Use? I mean after all, in the beginning it was supposed to be an incentive program and now it's going to be a club.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, but I was thinking about something that currently would affect the current status of a behavioral health provider, Joe.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Well I think – so the modularity question was important but I guess the underlying question is, it's a threshold-based question, given that they don't do these things very often, let's say they only did three labs a week or three labs a month and it was moderate in how it affected their practice anyways. But if they don't do these things very often, and it's not that important, and it really won't move the needle on true quality or efficiency or effectiveness of the practice, but now they can't be eligible for certain federal programs if they don't have a certified lab capability. They would actually be forced then to go buy the certified lab capability, and that certified lab capability would probably be somehow priced in proportion to the value of the federal program that would deny them payment if they didn't get one. So what I'm trying to be careful of is one, understanding how we intend to use certification, because that does matter.

If it's used in a penalty construct I think you'll actually see higher prices, higher costs for these organizations. If it's used as a voluntary certification for vendors that provide purchasers emotional assurance and technical assurance that the product has met some standards, that they don't have to spend as much time vetting it, reviewing it and such; that's a whole different thing. So, in this particular thing, just recognizing that the background says they don't do this very often, would they be denied access to federal reimbursement programs or bonuses or payments because the three labs a month didn't go through a certified lab component of a behavioral health EMR.

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

This is Mike. I think, and I don't want to talk so much about the federal penalties, but I think it becomes a business issue. Because if you start to go into integrated systems, the more you're in alignment with everyone else and if you're capturing and ordering in a structured way, then you can do a whole bunch of things that everybody else is going to be doing in healthcare and then you can play with your medical partners. Whereas if it wasn't – and that whole assurance of what you're buying allows you to do that, I think is the – is what leads me to say, yeah, let's do this voluntary certification module for this. So that if I'm a provider and I don't have any resources really, I need to be able to just see, yeah, it's been vetted, I can buy it, I know I can play with everyone else. I think it's a marketplace issue because if you can't do this in some integrated settings, you're not going to be able to participate. And if you don't have enough volume, then you probably won't need it because that organization won't want to play with you anyway.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Understand that, I guess I'm more curious about where natural market forces can succeed and in particular, this – you know we say voluntary, and that's nice to say voluntary. Meaningful Use is a voluntary program as well, right?

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

Um hmm.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

So it's okay to say voluntary, but if in fact not purchasing said certified product leads you – leaves you out in the cold with regards to certain federal reimbursement, that is, in fact, a driver for us to understand as we craft certification requirements.

Joseph M. Heyman, MD – Whittier IPA

And actually here in Massachusetts, we're still arguing about the fact that we have a law that says you can't have a license unless you are a Meaningful Use practice. We're arguing about the interpretation of that law.

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

So this is Maureen from SAMHSA. I mean I'm not aware of any intention or any discussions that have gone on around that type of thing within this context. But the one thing that I would say is, having a more modular program would, if that ever becomes part of the discussion, having a more modular program kind of would give those programs more flexibility to design it such that you're not placing an undue burden on the provider organizations.

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

And this is Elise from ONC. Our – impetus in starting this FACAs was really to respond to what stakeholders have told us from the BH and LTPAC setting. So really in terms of the – value of the program, it is to get to that point in terms of providers saying that they – or BH providers and LTPAC providers saying that they do not have the interoperability, they don't have the flexibility and they don't have the systems they need to actually benefit or become involved in kind of self-improvement. So we're looking at it from that vantage point and what will come out of the workgroup would help us to be able to help those stakeholders, and not thinking about it in any other way than to provide them with the technical capacity, the certification capacity to actually accomplish what they've asked us, they need help with.

Joseph M. Heyman, MD – Whittier IPA

So this is Joe. This is Joe and I would just say that for me, this is the same as the previous category.

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

So this is Elise again. What I will say is I would sort of encourage the workgroup to think about it in terms of what would be helpful to BH providers and to LTPAC providers. And if the workgroup – that a CPOE module, for example, would be helpful, then that seems like it meets the directional of the charge.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

The other thing we could do, Larry, is we could make a notation of the concern. I mean because I think none of us can absolutely predict the future. It's a valid concern and we want to highlight it, but not necessarily – not make your recommendation because of it, that could be the slide at the end. So that would allow us to continue to move on, having recognized there is a concern with probably any of these, if it's going to become a requirement for payment or the potential of a consequence of penalty because you do or do not have it, respectively. Then we may need to make a notation of that and keep going.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I totally agree with you. I think should this be used in any kind of penalty or missed opportunity, the simple fact that the testimony clearly states the majority don't have a need for these things for us to then assert that it should be part of certified. I think that standard of could be helpful is just too loose and low of a standard given that the likelihood of this being used as a reference point in federal programs or state programs is high. Call it an unintended consequence if you want, I think the likelihood of that is present and therefore I struggle to say yes to a requirement when the testimony clearly says it's not useful for the majority. I think we should look for things that would be useful for the majority and create requirements around those.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So when you say that Carl, then the only question I would ask you is the point that was brought up about interoperability.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

What's the question?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, I think the quandary that was presented is certainly your points are valid, particularly given, I can't help but agree with you that there may be a future where this becomes part of the requirement. But how do you deal with interoperability, which is one of the reasons that the conversation is in fact in play, where we can exchange with – provider-to-provider –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Oh, I thought –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

– how do you deal with that?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

If there's a requirement on the screen that said, be able to accept a C-CDA document from a healthcare provider into a behavioral health system, I'm all in and I vote yes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

But what this one is saying is, computerized provider order entry.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Gotcha.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

So I think – there will be certain requirements, I'd wholeheartedly say yeah, that should be in.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, because the question I thought of was, if we don't do any of these things, when we get into things like decision support, the question's going to continue and the reason it's going to continue is because it's dependent on lab results and on CPOE. So we can have that discussion when we get there?

Joseph M. Heyman, MD – Whittier IPA

But wait a minute Liz.

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

Well one –

Joseph M. Heyman, MD – Whittier IPA

Interoperability, Liz, is not dependent on these things. These –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well it's not –

Joseph M. Heyman, MD – Whittier IPA

– these things may be dependent on it, but it is not dependent on this.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

No, I agree with you on CPOE. What I'm saying Joe is that if we do not – we have to look at – these things do not stand independently. So if we decide that CPOE is not an appropriate requirement for temporary – even for modular, then they shall – good information, then we also at some point have to tie that to the other things that come as a result of CPOE, like clinical decision support.

Joseph M. Heyman, MD – Whittier IPA

Well we – didn't we have a similar discussion about clinical decision support? I thought we did.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yes, we did.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Joseph M. Heyman, MD – Whittier IPA

And I guess what I would say is, and this has been my point all along, and I'm trying really hard, honest, but to me the most important thing is what Carl just said, which is interoperability and a C-CDA, that is what is really needed. And the rest of this stuff is adding cost, but not much benefit. So, that's the way I feel about this.

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

And this is Mike. I think, the way I look at it is all these modules can be appropriate for behavioral health in different settings, but I think after we identify if there are any that aren't, to go back and then to prioritize which ones are most important. And I think everybody – interoperability, absolutely, I have my top three, I don't know if other people have other ones after interoperability. But I think then to prioritize those top three, then helps behavioral health providers to say, okay, if I'm going to play, I need to have these three functionalities. The other ones probably not, but if I do buy it, what's helpful to me is that it's certified, I know I can just hit the road and run with it as opposed to not.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, that's a – the only thing we need to consider, that's a great approach, the only thing I would say, because if we were developing certified criteria on the EH and EP side, recognize that when we say it's a – if we decide it is an option, then for the vendor, every "or" we put in there, then becomes required. So if you say, you can..

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

I –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

– you know where I'm going, right?

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

Yeah, yeah, and some vendors –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right. So –

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

– will do everything and others will just say I – to these things.

Larry Wolf – Health IT Strategist – Kindred Healthcare

This is Larry, I'm wondering – I'm hearing sort of a replay of some of the discussions around the existing certification criteria that group them into core, base and menu. And I'm thinking that there's a similar structure here, there are things like the pieces that make up interoperability, privacy and security that we would put into a core piece. And then there may be some other things that are really key to behavioral health in particular, that we might say these cross if not every behavioral health setting, pretty close to every and so they could be actually in some kind of base behavioral thing. And there's a bunch of things that are much more like menu in that they may or may not be useful, based on your setting. And vendors should pick and choose and providers should pick and choose, based on what they see as their need.

Joseph M. Heyman, MD – Whittier IPA

The only thing is – this is Joe, you have to remember that at least the way the government does it is, things that are menu in the beginning become core later.

Larry Wolf – Health IT Strategist – Kindred Healthcare

No, and maybe menu isn't even the right –

Joseph M. Heyman, MD – Whittier IPA

So maybe we shouldn't make them menu and core, maybe we should try some completely different terminology so that –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

Joseph M. Heyman, MD – Whittier IPA

– they don't fall into that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, good point.

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

And this is Mike. I mean we're always hopeful and we're out there advocating and working with Congress and stuff to try to make behavioral health providers at least Meaningful Use eligible, so, this may help them in the future as well, if we can get there.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I would only suggest that –

Joseph M. Heyman, MD – Whittier IPA

Careful what you wish for.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

– instead of making them Meaningful Use eligible after the stimulus is all gone and only penalties persist, maybe lobby for a stimulus program for behavioral health.

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

Okay, may that, but somehow, I mean the reality is they're going to need some resources to implement this, whether they are voluntary, not voluntary, whatever. But, that's a different issue, we're always hopeful they'll have some resources.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well, and I'll be an echo from the distant past. There was health IT adoption before HITECH and there is adoption among the ineligible providers. So I think the concern here is on the one hand, we want to highlight areas that we've heard are really important and maybe provide some clarity around, these are things that, if you will, I keep hearing from – the value from ONC is give us clear standards so when we implement something we know it's going to be interoperable. So maybe there's a message here to the industry, to the behavioral health and LTPAC industry where we can say, these are areas where there's consistency across all provider settings, this is a key base, this is the direction that not just ONC is going in, but likely other federal agencies. And there's a whole lot of gray area where there isn't clarity yet and we can't give clear direction.

And we're going to look to the market to see where people actually go. So I think we're trying to balance those things and I hear in this discussion the need to not be too inclusive by saying everything that might be of value to somebody, so put it in. Because that quickly becomes the kind of the all-inclusive "or," right, you have A, B, C or D, but you have to do one of them, it's really no longer a choice, you have to do – the vendors have to do all of them at that point. And so I think we need to be clear when we communicate where there's optionality here, what we mean by that. So maybe getting back to closure on the CPOE piece, am I hearing the same – within the workgroup that there's some dissent on going forward with this? And maybe on balance a little bit more, maybe a lot more support for supporting the CPOE in the same frame that we have this is helpful for some providers, not all providers and that needs to be communicated as these go forward.

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

It's Don, yeah, I think that latter sentiment would probably be the way to do it and to have the bigger emphasis be almost maybe a strong recommendation for only modularity to get at some of the concerns that Carl and Joe raised. The other question I had on CPOE is, and some of our prior comments about interoperability, so a lot of this stuff is based on licensing and are the – is the custom in these sites, do we think that the unlicensed “professionals” can access all interoperable information? Because I'm just wondering how much of the interoperable information and, obviously you need certain things in order to prescribe, but there's a whole bunch of other stuff that I think not everybody at these sites might have access to. So I'm just wondering about that as well, legal access.

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

You mean like clinical licensure, is that what you're talking about?

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

Yeah, I mean for example, if there's an HIV result in the lab test, right, let's just take that or the psych history or even the chem panel, right. I mean, in a lot of systems, a lot of the folks who I think are in behavioral health, might be locked out of some of this. I'm not positive, but let's say, I mean, would every caseworker, every staffer in these sites have that?

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

It depends on your site and how you set it up and if you give them the role-based access, like there would be some residential settings where they focus, the behavioral health and HIV that having that positive HIV piece would, they would have access to that, it would not be a problem. Other settings it might not be, but then that gets into what roles you give who in your organization.

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

Right.

Joseph M. Heyman, MD – Whittier IPA

And this is Joe. Usually the software allows different levels of access, so that within a particular group, you can assign access only to demographics for people at the front desk –

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

Right.

Joseph M. Heyman, MD – Whittier IPA

– and access to clinical stuff at another place and access to breaking the glass at another place.

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

But – they –

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

I'm just mentioning in the context of, as we're sorting out the question of what do these providers use, I think that there's more of a patchwork of what they would have, either legal and/or operational rights to it. I suppose you could say, it just makes more profiles – you make more user profiles to more finely – provide more finely grained access.

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

Yeah, and if you're behavioral health, you – most behavioral health organizations, organizations now, and if you work in a team setting, and if you work in a team setting, everybody has access to this because you're talking about it all the time. And if you're in the team, the psychiatrist doesn't hold back the medications or they don't hold back that they were positive on whatever, what the lab works were, they talk about it. Where you have the problem is when you're sharing with medical and medical thinks behavioral health shouldn't have it and vice versa. But, within behavioral health itself, it is pretty open in the team setting. Billing people don't have access to all the clinical stuff, but all the "clinical people," not just licensed clinical people, but anyone in that clinical realm, we share, because that's how you work in teams and provide treatment.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, I think usual discussion about role-based access, I think we've got that covered on the security piece. Any other comments before we vote on this and wrap it up?

Joseph M. Heyman, MD – Whittier IPA

Are we voting Larry – are we voting on what you suggested as sort of your summary statement?

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, I think that summary statement applies really to all of these, that these are all in the context of an optional program, modular program. I'm hearing – so, given what I said, one of the things we haven't been voting on is sort of how close to core are any one of these things?

Joseph M. Heyman, MD – Whittier IPA

I think we should try not to use the word "core" or "menu."

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. How close to uhh, I don't know what, essential, maybe that's not a good word.

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

Yes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Something like that or more peripheral or how broadly –

Joseph M. Heyman, MD – Whittier IPA

Okay, that sounds good.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– applicable these are.

Joseph M. Heyman, MD – Whittier IPA

Well Joe thinks this is peripheral.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. Maybe we will use central or peripheral.

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

Yeah, that's pretty good.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, Liz would go for –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. So, I'm sorry, so why don't we do a run-through on central or peripheral.

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

Just before you start that conversation – this is Jennie. I actually – I'm struggling with the distinction, particularly given a voluntary certification program that's built on a bunch of modules, and that's point number one. Point number two, I think it depends how essential or peripheral a module is I think will depend upon the provider type you're talking about. And so for example, in the CPOE module, I think computerized provider order entry will be very important and key for certain behavioral health providers and completely peripheral or irrelevant for others. So I just – it just seems to me that that distinction is, I don't know why this group has to deal with that distinction. It seems to me that that's an issue that either some future program would want to take into account, in terms of designing its program, or a provider would want to say, hmm, do I need that functionality, yes or no. And then vendors who want to target certain provider communities would decide whether they want to include that module, yes or no.

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

The only thing I would say, Jennie, with that – this is Mike, is that so how do you categorize interoperability? Because the interoperability piece everybody says, and I don't know what the right word, if it's not central, it's probably most important and these others are less important. You could live without all these others but if you don't have interoperability, I don't think you can live in the world and do care. But you could live without everything else, probably, or most of everything else, so how do you – I guess how do you categorize within that?

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

That's what I'm saying. If you're a psychiatric hospital, if you don't do computer – well, if you don't do – you're doing order entry as part of your regular course of business. If you're looking for an EHR to support your regular workflow, one would hope that it would support computerized provider order entry.

Joseph M. Heyman, MD – Whittier IPA

But don't you think the marketplace is going to provide that anyway? This is Joe.

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

Well exactly my point and so therefore I do not understand why this group is going through this exercise at this time of saying essential or peripheral because I think it is a complete – completely market or provider driven decision.

Joseph M. Heyman, MD – Whittier IPA

Well because, I think that for a large number of providers, a lot of the things that we're saying are peripheral, if you add certification to them, they become things that become more required and end up costing more to more providers and they add cost to each of the vendors.

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

This is Maureen. I mean it sounds to me like this comes down to whether the workgroup is going to be putting forth a recommendation for a modular program or whether we're going to be putting forth a recommendation for a more core program, we can use a different word, that applies across the majority of behavioral health providers. And if, and I – and maybe it's kind of the dividing that line between relevant to most versus relevant to some, so instead of this essential/peripheral, the kind of dividing it along those lines. To like is this relevant to most behavioral health providers or is it only relevant to some of them.

Joseph M. Heyman, MD – Whittier IPA

This is Joe. That sounds like a good compromise to me.

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

I could go with that, relevant to most or – I think interoperability is relevant to all, I can't get away from that, but then after that.

Joseph M. Heyman, MD – Whittier IPA

I would agree with that and I would also point out one more thing, Mike, and that is that really what's important is what is best for the patients themselves.

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

Um hmm.

Joseph M. Heyman, MD – Whittier IPA

What is best for those people, not whether a particular hospital is going to get something or not get something, so – or whether a particular provider can be part of an ACO, I mean it seems to me the most important thing is, what is in general going to be most important for the patients. And it seems to me that for continuity of care purposes, interoperability is a no-brainer, whereas the rest of this stuff, we're adding regulations and the ability to spend money on a certification program, which may or may not help any patients or some patients, but not most patients.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So this is Larry. Let me jump in with a piece of a counterbalance to that, Joe. So I agree with you about interoperability in terms of moving patient information. But I think that there's an argument to be made for various care plan protocols that are being put forward under banners of ACO or bundled payments, where someone's saying, okay so here is a heart failure program and – or here's a behavioral health program targeted into a specific set of diagnoses in patient population. And we want to ensure that regardless of what setting you're in that you're following this protocol. And so if you have a CPOE environment, you could use that as a way to implement the protocol and assure your partners that when you receive a patient, you'll be able to continue the care for that patient because you too can follow the protocol that they've defined. It doesn't mean there aren't other ways to follow protocols, we've been doing protocols on paper for decades, but if we're moving to electronic, that kind of use of protocol, in fact, becomes part of supporting patient care as we integrate across settings.

Joseph M. Heyman, MD – Whittier IPA

Well then once again, I would have to say, you have to remember that technology is just a tool, it's not – it's a tool, it's not the care itself. And if we're creating protocols around the technology instead of the care, I would say that we're making a terrible mistake.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well and I think the argument that Mike's been putting forward is that when you participate in these programs that yes, you need to follow the protocol, and that doesn't dictate a specific tool. But I think we're seeing examples of having the protocols automated can, and again, it depends on how well they tie to workflow, can improve compliance with protocol and hopefully that results in better care.

Joseph M. Heyman, MD – Whittier IPA

Well, I hope you're right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, we're not going to resolve that here.

Joseph M. Heyman, MD – Whittier IPA

Right. To me, it's, as I said on some other call, you have to give a damn and a lot of this stuff is very peripheral to giving a damn and it makes people concentrate on technology instead of human factors. But I'll leave that alone, let's just move to the next one.

Larry Wolf – Health IT Strategist – Kindred Healthcare

We have human factors coming up on a subsequent slide, so let's –

Joseph M. Heyman, MD – Whittier IPA

Good, I'm glad to hear it.

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

Larry, this is Michelle. I know that was really an important discussion to be had in the group, but I'm just concerned about the number of slides to get through. So I don't know if there's a way that we can rapidly move forward, but just want to make everyone aware of the time.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you for the time check. And I see you've already moved us to the next slide on patient engagement. So let's take on patient engagement.

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

During the hearing we heard from our patient advocate that patients should have the opportunity to review and correct their record. We also heard from an addiction treatment provider that certification interoperability would greatly help patients to understand their addiction. And they went on to say that rigorous quantification of data across the longitudinal dimension would be very helpful in showing patients how the development of a disease affects their behavior. And so our proposed areas for certification would be to support the ability to electronically retrieve patient-specific education from content knowledge resources. Support the ability to provide secure online access to health information from patients and authorized representatives, to electronically view, download the health information in concordance with a Consolidated CDA standard and transmit such information using ONC specified transport specifications. Support the ability to enable a user to create a clinical summary in accordance with C-CDA in order to provide it to a patient and finally to support the ability to use secure electronic messaging to communicate with patients on relevant health information.

Joseph M. Heyman, MD – Whittier IPA

So continuing my theme, this is Joe. I agree with everything that has to do with the C-CDA on that slide. I don't think the ability to be able to electronically retrieve patient-specific education from content knowledge resources needs to a) be certified, because anybody can do it on the Web and b) because the stuff that is in EMRs that meets certification requirements is not nearly as good as some of the stuff that's available on the Web.

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

This is Mike, I would agree with exactly the same thing.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I have a question, Carl, on the C-CDA. One of the interesting nuances of Meaningful Use on the healthcare delivery side was a requirement that wound its way in to try to do a custom edit to the patient after-visit summary. And the rationale for the custom edit to the patient visit summary in part tied back to behavioral health concerns that we don't want to put paranoid schizophrenic on the after-visit summary because paranoid people get paranoid when people think they're paranoid. And it wound into a whole lot of requirements around that. And as I look at this, it feels a little bit like square peg in a round hole, I wonder if what we should do is figure out, from these folks, how they imagine the information to flow back and forth and what specific limits might be even more appropriate in the behavioral health world. I'm a little bit nervous about just a blanket yes to this, although I agree with others there that ability to transport information is good. But I also recognize that it's generally thought of as a two-way transport.

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

You know, some of the issues there are actually how providers document to begin with, up front.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Um hmm.

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

And we do a lot of education with providers now around, they need to move from documenting at the end of the day to concurrent documentation and learn what words to use at the time that they're doing it. So I'm not – I don't know, you go back and edit – you need to have the editing piece in there, and people should be careful about, know the patient. Some patients are fine with their diagnosis, they know what it is, you shared it with them, it's on their treatment plan, you talked about it in the session, this is what we're working on, these are what you do, this is what I do. It should be all provided to them up front. Now that one particular patient that's so paranoid you can't talk to them about it, well then, you haven't even gotten to that point with them, so it shouldn't be documented in that particular area.

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

So Mike, this is Sue and I think perhaps what's being referenced is that in the requirements around clinical summaries for the office visits, there are requirements that talk about the ability for the provider to customize the data that's included in the clinical summary. Am I summarizing that correctly?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah, generally, I think so. Yeah.

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

Okay.

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

I guess, but it's one of those –

Larry Wolf – Health IT Strategist – Kindred Healthcare

So Sue you're suggesting that –

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

– things that would be over and above.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– that the clinician could document a diagnosis that hasn't yet been reviewed with the patient and decide in the summary to not print that because they feel it would exacerbate the condition rather than help resolve it.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Well in some of the commentary, you've indicated that certain physicians – it would be a detriment or a negative for them to actually fully document the case. Because if they had to share it with the patient, and I remember the discussion specifically around behavioral health, it would be a detriment to the treatment of that patient if you did the OpenNotes Project and the raw diagnoses in ICD-10 form, etcetera. That a healthy part of what they're trying to do is help the person learn, understand and cope with a situation in a world where being labeled is extraordinarily painful. My point was, I remember that segment of that discussion which lead to a pretty sophisticated tweak that creates a lot of effort in work to develop and I wonder if, given that this is entirely behavioral health, that if, in fact, this deserves further study and understanding before we apply the traditional medical requirements onto this particular situation.

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

Right, and I'm still trying to retrieve this a little more, but when they're talking about the customization, they're saying that the technology must permit a user to select at a minimum the data that's in your common Meaningful Use data set. And then there's also some just generic office type information about the date and time of the visit and whether – the purpose of the visit, any clinical instructions, things like that, so –

Joseph M. Heyman, MD – Whittier IPA

So, this is Joe. I think you guys are going way beyond what's the current certification requirements. I just want to say that, I mean, I can't do what you're just suggesting in my EMR and it's a certified EMR.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I think it's a Stage 2 requirement.

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

It is a Stage 2 requirement.

Joseph M. Heyman, MD – Whittier IPA

That you can –

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

Yeah, but not in this section.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

No, you may have to plan on an upgrade.

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

It's under 3 –

Joseph M. Heyman, MD – Whittier IPA

What is the requirement?

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

It's under 314, little "e," number two, and the second bullet under there talks about customization, enable a user to customize the data included in the clinical summary. And then number three says minimum data from which to select and it says EHR technology must permit a user to select at a minimum the following data when creating a clinical summary and it talks about the content of the common MU data set. And then a specific set of elements related to an office visit, date and location of the visit, reason for the visit, any immunizations, meds administered, things like that.

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

Is that someplace else Sue or is that – because I don't see that on the screen in front of us. Or is that just left out of what's on the screen?

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

Oh, I just – what's on the screen in front is the reference to specific rule numbers –

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

Uh huh.

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

– and the information that I'm reading is actually what's part of that 314(e)(2), which is the clinical summary.

Joseph M. Heyman, MD – Whittier IPA

But that's not a minimum – that's a minimum data set that has to be included or you have to be able to ex –

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

It's part of the complete EHR, it's not the –

Joseph M. Heyman, MD – Whittier IPA

– is that you can exclude portions of the clinical summary? Is that what I'm hearing?

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

Well, that you customize it, Joe.

Joseph M. Heyman, MD – Whittier IPA

Well, I don't know what that means, unless it means that you can exclude parts.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

It means that you can exclude parts and there was some vague reference to possibly being able to add and then I think there's an implied requirement that you'd probably need to retain an archived copy of what you handed the patient.

Joseph M. Heyman, MD – Whittier IPA

But let me – but that's not the C-CDA, that's the clinical summary.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I think it also applied to – didn't it?

Joseph M. Heyman, MD – Whittier IPA

I'd be very surprised if we are now going to be able to exclude portions of the C-CDA that are coming out of our EMRs. I can do what you just suggested in my clinical summary, absolutely. I can eliminate parts, I can keep parts confidential, but not in the C-CDA.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I don't know who was talking on behalf of ONC, but that – was that requirement extended to the VDT, the view, download, transmit in the final rule? No?

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

So, in – this is Sue, yeah, I'm sorry. I've been working with Maureen. So, the requirements that I have been reading were what's listed under, what's referred to as a clinical summary. And it does require that summaries be created in a Consolidated CDA and that it also has those customization requirements that you had mentioned. Now, and forgive me, so you're asking about what's under the view, download and transmit?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I apologize, I don't want to get us too far afield. My greater point was that behavioral health was one of the reasons that that complication was added and as I looked at this on the screen in front of us, my only comment was, we may want to rethink this from a pure behavioral health perspective, rather than trying to apply the other standards that were created onto behavioral health. Because I think it's going to have enough of its own characteristics that it should be thought through.

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

Well, that's part of the piece and I don't think there was any issue that you would not have the ability to edit your summary that you give to the patient, right. So I don't think that's an issue with – if that's part of this patient engagement component. I would not have any – certainly don't have any problem with that because for the reasons that you're identifying, people may need to do that. So, that would be part of this patient engagement piece and component. I'm like Joe, I just think the ability to give over on the right hand side, the first bullet, I don't think you need that in it. The rest of it all fits and –

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

Have we thought about this from the admittedly limited set of patients who are actively homicidal? I say that as somebody who takes care of these people in the ER, right. They're a group of people who – that we have guards on and if they're not actually under arrest, there's a group of patients here who have, I think even some very different needs than the paranoid schizophrenic type of example. I think we may just want to have that as another one of our test cases here.

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

Um hmm. Yeah, you may edit that to give to the patient, but when you send along the CDA to the emergency room, you're not going to exclude that, I would hope that you would not exclude that. And actually, if they're homicidal, you have a duty to warn, so you have to include it.

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

So perhaps in terms of this discussion here, maybe there's something to the effect of, general agreement on this proposal with the following modification that this – the functionality – the criteria should say something when clinically appropriate or clinically indicates or something.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I wonder also if we could, again, I think we may want to work this one up from the ground up. One thing that healthcare interoperability was designed to be was more or less symmetrical. I think with regard to behavioral health it makes sense to stream the clinical record in to behavioral health, just to understand all the issues, the situations the patient's dealing with, plus anything that's prescribed there is important. But I'm thinking that it may not – there may be asymmetry here in that what comes back out of behavioral health needs to be thought through carefully before we apply the literal rules or suggest that the literal rules be applied. I agree this is a very important area in interoperability to and from behavioral health is probably the biggest thing we should focus on, but I think it needs to be carefully thought through, given the complexity of it.

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

I'm not sure what – identifying Carl is that – is it to edit what you give to the patient or edit what you give to the next provider?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Well, there are three states, right. There's what you would hand to the patient and then there's what your EHR will transmit to another EHR, but then there's this thing in the middle called view, download and transmit.

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

Um hmm.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And that's a complicated one because you're not certain where it'll go, it might actually go to another provider who would take it on face value that was accurate and complete. I don't know if there's a standard to denote that it's an altered version of the record rather than the true version of the record, but it will have the provenance that ties back to the original source EHR. So I think in this case that middle one in particular makes me have an antenna up on how that will actually work.

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

Okay.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Again the flow in is fairly straightforward in my mind, it's the flow out that gives me pause.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So Carl that concern – this is Larry. That concern would apply really to any edit involved with a view, download and transmit right, because on the download and transmit site, the recipient – the eventual recipient won't know that edits have happened.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah, I think it's in general a puzzle that has not been solved.

Joseph M. Heyman, MD – Whittier IPA

Although – this is Joe, we do have the same problems, even if you exclude behavioral health, about other sensitive portions of a medical record right now, in the Meaningful Use program, for people who are part of the Incentive Program and I guess most of us are figuring out a way to handle that.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I think the benefit in the general healthcare side is that you can go health system to health system, and I think the foundation is being built for that. With regard to behavioral health, I'm going to – I'm making sort of an inductive leap that we'll probably need to put more control in the patient's hands, just given the state laws and regulations around confidentiality there.

Joseph M. Heyman, MD – Whittier IPA

I see what you're saying.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

So my supposition is that VDT will probably become a main way to move information, at least out of behavioral health. We might be able to fall back to the general healthcare principles that we're using in the getting information in to behavioral health side. Again, trying to – the puzzle with this is you're trying to imagine how it might be used in the future as we decide what we should say are requirements. So, obviously is a lot of conjecture.

Joseph M. Heyman, MD – Whittier IPA

No, I got it.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so I'm hearing that while we'll probably have a focus on consent issues. That given that one method of handling consent would be to say to the patient, here's your information, you choose who you give it to now sort of creates a heightened concern about any edits happening in what's given to the patient and then gets communicated downstream to other providers without any knowledge that edits have been made.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Um hmm.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so I'm hearing two – I'm hearing one pretty strong consensus here, that we should pull the patient-specific education, because there doesn't seem to be a sense that the information is as good as what's otherwise available. Not that the capability might not be reasonable, but that what it actually gets you to, our "give a damn" criteria, doesn't seem to pass that test. And that there are questions about how view, download and transmit would work with this population. I'm assuming all the things we haven't talked about, things like secure messaging are perfectly reasonable things to have, might even be of high value in these settings.

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

Um hmm. Yup.

M

Agree.

Joseph M. Heyman, MD – Whittier IPA

Silence is golden.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, let's move on.

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

Yup, there you go. New rule.

Larry Wolf – Health IT Strategist – Kindred Healthcare

(Indiscernible)

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

All right, labs/imaging. During the hearing panelists stated, in their experience medical doctors are mostly interested in receiving information from behavioral providers on medications, diagnosis and repeat labs. And again we heard that ineligible behavioral health providers typically do not rely on lab tests or radiology; however, this could be important to some behavioral health providers. Therefore a labs and imaging module would be useful to address the diversity among provider types. Our proposed areas of certification would be to support the ability for an ambulatory setting to be capable of electronically receiving, incorporating, and displaying clinical lab tests and values and results. Support the ability for an inpatient setting to be able to generate lab test reports for electronic transmission to ambulatory provider's EHR systems. And finally, support the ability to electronically indicate to a user the availability of a patient's image and narrative interpretations and enable electronic access to such images and narrative interpretations.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, does this all fall into our earlier discussion about labs and imaging might be useful in some context but not all?

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

I think so. This is Mike.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah.

W

I agree.

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 there's also a separate thing on images, like when you're talking about images you're talking about some things that may be monstrously large, may be wrapped with a whole bunch of other software complexity, depending on let's say you wanted to arguably display volume rendered CT scans or something like that or future complex MRI data sets. So if you're putting in the lines on images as opposed to let's say, narrative image reports, you're pulling a lot of stuff and potentially some other tools and potentially some significant expenses into – that these folks would have to bear. So that would be – I think labs are different than images in this kind of a setting.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And I think – I guess this is also a question of getting the specifics right. So, the heading for §170.314 (a)(12) is image results and so the narrative will clearly – is generally compact, but you're right, the images can be vast.

Joseph M. Heyman, MD – Whittier IPA

Well there certainly would be no reason to require the images.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

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

Right.

Joseph M. Heyman, MD – Whittier IPA

Also, this is Joe –

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 look at the right side, it says availability of patient's images and narrative interpretations.

Joseph M. Heyman, MD – Whittier IPA

Yeah, well I would be opposed to that, I think that's silly. But I would just like to bring one other real-world thing about the modular idea. If you have an HIE and it's not connected directly to your EMR, and you have an EMR and you're doing your ePrescribing through a module, that's three different things that you have open on your desktop at the same time, and you have to toggle between them. We need to be careful that we don't put so many modules on the desktop that it drives people crazy, so, because that really is something that will bother the person's workflow. So while I understand that these are all modular, I think that people would prefer to find them all within the same software than to have them all separate modules all over the place. I just bring that up because it just occurred to me when I was thinking about getting a lab work in a separate module, and getting the C-CDA in another module and getting the recording in the third module and having them – it just I get concerned about that.

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

Yeah, I would agree and I think that's why we – why providers should be able to look at the vendor and see which modules they have and the ones you need, you all buy from the vendor.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah, I think that's how it would exhibit itself in practice, you'd have some vendors that focused on practices that didn't do a lot of lab, and you'd have vendors that focused on practices that did lab and they brought that piece in as an integrated part.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, module doesn't require they be disjoint modules, but you're right Joe, that becomes – could become quite confusing and even a safety issue, if the windows are all independent of each other.

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

Yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. So we have a concern here about images, otherwise I think this falls into our general earlier discussion. So since we're very close to being out of time, I want to make sure we get to talk about the next one, because I expect there'll be a lot of opinions on this. Let's move on. Thank you.

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

All right, and generally heard that there was a need for usable systems that support workflow, although in contrast, I think it's important to note that we did hear from one panelist that did not support a voluntary certification process for usability. They recognized that it was important, but it was somewhat subjective. So with that, our proposed areas for discussion are around supporting user-centered design processes, which must be applied to each capability an EHR technology includes, that is specified and the ONC medication-related certification criteria. And also supports the requirement that developers must indicate the quality management system used in the development, testing, implementation and maintenance of the ability of EHR technology for which certification is sought.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, to – this is Larry – to offer a piece of framing on this. So, I guess a reminder, and maybe Carl and some of the other vendors could speak to this, the user-centered design process doesn't say, users tell you what they want and you build it. This is a much more nuanced and sophisticated approach to building ever-greater levels of usability into products based on human factors and detailed reviews of what users are doing and things of that type. And that the second one, the supports a quality management system is looking at the processes the vendors use to create their software and that there's structure to that process and that in itself is amenable to performance improvement over time. So I think that's how this is intended. Any comments about both the intention and how you guys think it's playing out.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I – just in looking at it – you'd asked – Carl here, looking at the hearing testimony, they – the behavioral providers do not believe it's necessary, and having experienced the full weight of it, at least in the early stages, and the lack of real benefit from it, I would simply vote to not have this one in there. I think we'd be doing a disservice to the behavioral health providers and the vendors that serve them in total by putting this requirement on them in order to be called certified.

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, yeah, this is Don Rucker, having – as a former vendor, I think on some level you're always doing this and the ultimate test of this is really sort of that marketplace usability test. I mean, I've been part of many of these quality management processes and systems and user-centered design and I'm just not sure how much they sort of really ultimately add. But I think they do – in terms of end-user benefit, but I think they do add a lot to complexity and delays and making changes to the systems. I think they have a probably complicated profile if you're an end-user, just trying to get through your day using the software. And the things that I've seen, both as a designer and a user, I don't actually think would be typically fixed by these things. I mean if they were fixed by them, that's one thing, but I don't think they can be fixed by these kinds of processes, that's just an empiric observation.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Wholeheartedly agree.

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

Yeah, this is Stan Huff, I agree as well. I agree in having good systems, I don't think it's a good idea at all to try and specify how people get to good systems.

Joseph M. Heyman, MD – Whittier IPA

Are you three guys talking about both bullets? This is Joe.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yup.

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

Yup.

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

Yup.

Joseph M. Heyman, MD – Whittier IPA

Well, you've persuaded me.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I'm hearing that, while we have users saying they want high usability, there isn't a sense that in fact, these are consistently good ways to get there.

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 the other thing to throw out, just for maybe our or the public understanding of this, and maybe it gets put into the comment is that a lot of the usability is really related to the UI tool set built – provided by the programming framework as opposed to things that are necessarily done by the vendor, right. Let's say for example you're programming iPhone or Android, your constraints on what you can do are very material, so I think a lot of it's sort of as complexity that goes well beyond "it's under the vendor control to begin with." And I think that may be reflected in some of our commentary or suggestions to the Standards and Policy groups.

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

Just before we take a boot or whatever on this topic, Sue, can you describe what's on the – what are the underlying requirements under these two regulatory provisions? Sue, are you on the phone or on mute?

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

I'm sorry there Jennie, I was talking to mute. No, if you can give me a minute to pull that up, that wasn't part of my original grid, so let me – let me look around.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So while you're looking, Sue, we'll point out that mute buttons on conference calls are an example of poor design.

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

There you go –

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

No, just when it's on – when you're on mute and talking, it should say, you're on mute, you're on mute, you're on mute.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

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

That little hand that comes out and smacks you and says, wake up, wake up.

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

So, I was a little concerned that Apple, who sort of many people would argue is the greatest design – software design shop ever, has designed it without that consideration.

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

Okay. Sorry folks, this –

Joseph M. Heyman, MD – Whittier IPA

It should send you specific educational materials about how to mute and un-mute, automatically when you're muting.

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

With a certification require – certification compliance requirement on time –

Joseph M. Heyman, MD – Whittier IPA

Exactly.

Larry Wolf – Health IT Strategist – Kindred Healthcare

My phone has a very odd feature, when I put the headset on mute, I get a little beep every 15 minutes. It's beyond me how that's useful.

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

Okay, so we were looking at the safety-enhanced design, I don't know if this is going to help a whole lot. What the rule actually says is that the user-centered design process must be applied to each capability an EHR technology includes or is specified in the following certification criteria. So, this would be – it's going to be referring back to our requirements under clinical information and looks like transport, but it applies to specific rule numbers.

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

Okay, how about the (g)(4) requirement?

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

The quality management system; okay, so that says for each capability that an EHR technology includes and for which that capability certification is sought, the use of a QMS in the development, testing, implementation and maintenance of that capability must be identified. And then it talks about if you're using a single QMS, it only has to be identified once, if different ones are being used, then each QMS applied would need to be identified. This would include the application of a QMS to some capabilities and not to others and then if no QMS is applied, to all applicable capabilities, such a response is acceptable to satisfy this certification criteria.

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

Thank you.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So this is really the very beginnings of learning about what people are doing for their quality management systems, it sounds like.

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

Yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right, because it's asking them to report what they're doing, either consistently across all their modules, within single modules or if they're not doing anything, to say they're not doing anything.

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

Exactly Larry, it's just saying that you need to be identifying what capability was used or the absence of such testing.

Joseph M. Heyman, MD – Whittier IPA

And what is the value of that? No, I understand the value of the testing, but I don't understand the value of asking and then getting either answer and then certifying it.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think the intention here was for ONC to begin to learn about what people are doing.

Joseph M. Heyman, MD – Whittier IPA

Well then, I don't think it's very important for this.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. That seems to be the consistent message we're hearing here. Okay, let me take a quick look ahead, how close we are to the end, because we're at 28 after and I have a hard stop today.

Joseph M. Heyman, MD – Whittier IPA

I hope that's h-a-r-d.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Hopefully my heart with a "t" will not stop –

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

So Larry, this is Liz, just before we conclude and open up for public comment, I just wanted to have the behavioral health update on – related to the Privacy & Security Tiger Team.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Great.

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

So, I'll take a minute to say that. So the Privacy & Security Tiger Team has made their recommendations – the Meaningful Use recommendations and there are a couple of items related to consent management. We wanted to invite one of the Co-Chairs from that Tiger Team to come and present on a future call so we can better understand what they're recommending. In addition, I think from the last call there was a request to learn a little bit more about details related to the data segmentation work. So we'll be coordinating with Jonathan Coleman who led that work, to also provide an update.

And then in terms of just an update regarding the actual Standards, just so everybody is aware, the HL7 Implementation Guide related to data segmentation completed normative ballot in January of 2014 and was successfully reconciled this February.

And then we have some updates on pilots. So, we were just made aware from Cerner that they're Behavioral Health Solution will include these data segmentation standards using Direct. And they plan to incorporate it into their full production release for April of this year. Their Cerner Millennium Solution, design teams have begun to work and recognize the process for data segmentation and to receive the data from their Cerner Behavioral Health Solution. So they expect that the functionality will be in a production release later this year. And then in terms of HIMSS, if any of you are planning to attend, at the Cerner booth at HIMSS, they plan to demonstrate the marked up CCDs being sent between their Cerner Behavioral Health Solution and their Cerner Millennium Solution. So, just wanted to make sure that the workgroup was aware.

M

Thanks.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, so it sound like we're going to have some specific updates on both management and data segmentation as part of our wrap-up or somewhere squeezed in before we present to the Policy Committee. Is that right?

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

That's – yeah, that's right. But I just wanted to make sure everybody was aware, particularly for HIMSS, that there's a – if you want to go see the demo, it's – they'll be doing a demo at the Cerner booth.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right. Okay, so we've got a couple of dangling ends here, but I'm going to let them dangle for the time being. Can we open up for public comment?

Public Comment

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

Operator, can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have no public comment at this time.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. Well, I want to thank everybody for their time today. We meet again in a week. Thank you very much.

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

Very good. Thanks, bye.

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

Thank you.

Public Comment Received

1. I think that sounded like an advertisement for Cerner.