

Implementation Workgroup
Draft Transcript
June 29, 2012

Presentation

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon everybody; this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee's Implementation Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself before speaking. I will now take roll. Liz Johnson?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Liz. Cris Ross?

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Cris. Robert Anthony? Robert Barker? Kevin Brady? Anne Castro? Simon Cohn? Tim Cromwell? John Derr?

John Derr – Golden Living, LLC

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks John. Carol Diamond? Timothy Gutshall? Joseph Heyman? David Kates? Tim Morris? Nancy Orvis? Steven Palmer?

Steven Palmer - Texas Health & Human Services Commission

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Steven. Wes Rishel?

Wes Rishel – Gartner, Incorporated

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Wes. And Andrea Sim for Kenneth Tarkoff?

Andrea Sim – RelayHealth – Vice President of Product Management

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Andrea. John Travis? Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Micky. Is there any staff on the line?

Carol Bean – Office of the National Coordinator

You've got Carol Bean.

MacKenzie Robertson – Office of the National Coordinator

Thanks Carol.

Chris Brancato – Office of the National Coordinator

Chris Brancato supporting the office.

MacKenzie Robertson – Office of the National Coordinator

Thanks Chris. Okay Liz and Cris, I'll turn it back over to you.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Great, I think Cris is going to lead us through this process. Cris, you want to start.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

You bet. So, does everyone have a copy of the agenda which was distributed earlier? I know we're just getting test scripts in just a moment. If you can look at the agenda, what we wanted to do today was to take about a half an hour to walk through one of these clinical test scripts, and again, these scripts are intended to support certification under Meaningful Use, 2014 edition. So we thought we'd spend a half an hour walking through those test scripts, we thought we would spend probably about 15 minutes having a discussion between workgroup members and staff about what's the possible inventory of test scripts. So, is it bigger than a breadbox, are there going to be five of these or 50, and just see if we can get a level expectation about that that looks like. You'll see that there are three draft scripts that were sent out, and we'll choose one to walk through today.

Then we thought what we would do would be to assign the known scripts, especially the first two drafts, to members of the committee and have some ideas about what we would do for future scripts. And then in the last few moments before we go to next steps and public comment, is we may want to identify additional expertise that we need for temporary assignment to the workgroup. As Liz and I talked about this, we really believe that wanted to make sure that we had good clinical input and there are a limited number of clinicians on the workgroup, and we believed that we probably would need to recruit some additional ones. So, as we work through this, for example, I'm not a clinician, but Liz is, so I'm going to take a facilitation and process kind of leadership piece and Liz is going to take more of a role of having taking the clinical leadership role. So that's our agenda for today. Before we dive into the first test script, do any of the workgroup members have comments, questions, suggestions for improvements, and so on?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

The only thing I would like to do Cris, before you go there, is I'd like to go on record to say, so that we're clear that these scenarios are still in draft form, and so there's probably significant work. They're very well written, but we want to be sure that it is clear to the public and to our workgroup that these are still in draft form and that our job is going to get them into a more permanent form, and then I'll turn it to the workgroup for questions.

Wes Rishel – Gartner, Incorporated

This is Wes.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Hi Wes.

Wes Rishel – Gartner, Incorporated

So, is the ultimate job of this workgroup to write the body of these scripts? Last year we kind of reviewed them, I think.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

These are new scripts Wes...

Carol Bean – Office of the National Coordinator

You've never seen these Wes.

Wes Rishel – Gartner, Incorporated

I understand, but at the... what I'm trying to do is understand the overall flow getting ready for meaningful use certification, is it that the... we have decided that the implementation workgroup writes the scripts and some contractors have helped to get us started, or is it that there's another workgroup somewhere that's writing scripts and we're reviewing them. I'm just trying to understand.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Carol, do you want to take that one?

Carol Bean – Office of the National Coordinator

The ONC is responsible for doing these scripts. So we are drafting them, we in staff and supported by our contractors, so what... to the extent that you want to draft original text and post, that's certainly fine, but primarily what your fearless leaders have agreed to on your behalf is very careful review and input and heavy-duty suggestions, those kinds of things. In particular, validating the clinical veracity of this approach, etcetera. If Cris...

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

I think Carol, that's right. I think what we're trying to respond to and Wes, please speak up with your opinion about this too, I think if there was a critique, a constructive one was compared to meaningful use 1, for 2014 edition, we wanted to make sure that there were test scenarios that were a little bit more detailed, a little bit more specific as opposed to certification that happens simply on an attestation basis. So I think the goal here is specificity and guidance to the testing authorities.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

And I would say Cris, and please comment. As I listened to the conversation Wes, I would say that the reason that Cris and I talked about bringing clinicians in is that we have, not a lot, but we have a little more time to look at these to make sure they are clinically relevant and we would serve as subject matter experts to Carol and her group, and that we would not be generating these on our own.

Carol Bean – Office of the National Coordinator

That's correct and I'll add in a little bit that the requirement, the rule that was published what 2-3 years ago, required us to... required the program to be able to certify modules and define what a module was, which was something that could satisfy one criterion. Where I'm going is, we are not doing away with the capability to test individually, we are still required to be able to test each and every criterion on its own, with the applicable privacy and security criteria. But, listening to this group and the public and many folks, there is a lot of interest in being able to join various related criteria together in a threaded fashion, in a way that makes sense clinically, etcetera. And so that is our goal here, and I just want to be very clear that the goal is not to replace what I would call the unit-based testing, that has to be available. But for...the hope is that, if we are successful where multiple criteria would be strung together, this is to ensure that they're strung together...that we have the capability to string them together and to do so in a sensible fashion. Does that make sense?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

I would say too that it... so I think these are terms people are familiar with, the unit testing or the testing that shows the availability of a specific functionality based on criterion or certification criteria, is one... and the required doc... element, like Carol said, so they can get modular certification. What we had hoped, and I think we will accomplish, is that we could actually... would be... even almost usability testing, but you wouldn't go that far to say this is sort of how you would use a clinical scenario to test the functionality across a process.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

I think it would help to some degree, there's actually a document that's attached to, let's see, which of the emails is this attached to, it should have come out to everyone in the group, it's labeled ONC's FACA meetings; it's got 6/29 materials. And on that is a diagram on scenario-based testing, and I can't remember if we went through that with the full workgroup or not.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

We have not.

Carol Bean – Office of the National Coordinator

I don't think we have.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, it might be really useful for Carol, whomever you'd like to, to walk us through this, because I think it describes a little bit about what you're saying and it informed our...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

I agree.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So maybe we could look at that, and then I would suggest that we actually get into looking at one of these test scenarios. You'll find that they're really well done and I think in looking at them, will give us sense of kind of what the structure will look like going forward. So, Carol, do you want to walk us through the attached PDF, the 1 that's labeled scenario-based testing 6.21.12.

Carol Bean – Office of the National Coordinator

I can do that, but I had hoped that Scott Purnell-Saunders was available to do this.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Even better. Is Scott on?

Carol Bean – Office of the National Coordinator

I didn't know if he was on or not, because he's also going to probably going to need to walk us through the scenario.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, I had sent him an email just a little while ago and he had indicated, I think that he was going to be on this call. So, I wonder if we just have a logistics issue.

Carol Bean – Office of the National Coordinator

He's supposed to and I'm assuming he will, at some point. Okay, but I can go through this until he starts, or until he joins us. We considered basically... as we did a fair amount of analysis on our end, and a lot of it was listening to... considering what had been recommended over the past year by this group and others, and came up with a couple of options for what has been termed in some cases, scenario-based testing, workflow-based testing, incremental testing, threaded testing, all those kinds of things. They are to be contrasted and we came up with...what we were discussing was the various options that somebody, a vendor-developer who approaches a test lab for testing of a product or system would be able to choose. And our thought was, basically, to have two options; one would be the unit-based testing that's in the PDF scenario-based testing diagram and that's option one. This is required by the rule or the regulation as I said earlier, and here this is where each criterion is tested individually, in no required order. And the ATCBs throughout this temporary certification program, has thus far, many of them have done a little bit more scripting than that. So right now you could test them just in numerical order by the number and the regulation, which probably doesn't make a whole lot of clinical sense. And so a lot of the ATCBs and a lot of the folks requested being able to do them in an order that made sense, both technically and clinically. And so, with that, we came up...and so where it says current method of testing is not exactly accurate, but that's currently what is required and it is currently an option.

So, we came up with two essential options for doing the scenario-based testing and one is essentially taking the individual unit-base... the unit... the test that would be done in the unit-based testing and essentially specify the order in which they would proceed. And this would be comparable to the order in which a clinician would interact... might interact, with the data. Now the one advantage of this type of testing is that you can, for us, you can still use the unit-based test, you just do them in a particular order, so you change the order, and for a product that comes into the ATCB as a test lab, that only wants to do some portion of the criteria, that particular criterion could be removed from the testing thread, and the example that's shown here is where say criterion 3 went to criterion 1 then criterion 4 was tested and after that criterion 2 was tested. And if somebody came in with something that didn't meet or didn't intend to meet the functionality of criterion 3, you could just easily start with criterion #1 and proceed. Or, if you wanted to yank four out of it, you could yank four and go three, one, 2, in this particular order so something can be skipped or left out and it would not mess with the validity of the test itself.

Another feature of this that isn't... I don't think it's addressed in this particular diagram, but the data would be consistent. Instead of having in the option 1, where each criterion is tested individually, there's no need for the data to be... to relate to one another. You have one data set for criterion #1, another data set for criterion #2 and so forth. Here, what we are intending is that the data will also flow. Now again, it's going to be relatively complex and take some work to be sure that if something does not go through the entire thread, that you know where to pick up the data that we have... the test labs know where the data should begin or what those data should be, so we also are having to create the data for the individual criteria, but what we're trying to do is create it so that it maps, the data align and map from one criterion to another. So we believe, if we hear that that's not a useful thing, then we can stop spinning our wheels on that, but I believe that it's really useful and it would be great... what we're targeting is having sort of a unified data set.

Option three, and put the star by option two because that's the one we see happening. Option 3 is what I call black box testing. And this is where a product is put through a prescribed scenario, you don't know what the outcome is, you don't have traceability, you can't determine what the logic is and the process, you don't know what all that is. And that's one of the requirements for test procedures and for testing; there's traceability from a particular test, a particular test element, all the way back to the criterion, and if you just put something in and wait and see what comes out, without being able to examine it at each intermediate stage, then you don't have that traceability requirement, may meet it, but you can't basically prove that it was there. So, and you also have no capability to skip a step, so you couldn't... you would lose the modularity aspect. So, essentially what we are proposing is something that looks a lot like option 2, is to take that approach which we see as sort of an intermediate step, but that comes...or not intermediate, but it is a final step, but that it satisfies the needs and the desires for the scenario-based workflow, incremental, threaded, whatever term you care to use, as well as the traceability requirement, the logic requirements and the modularity requirements. So...

Wes Rishel – Gartner, Incorporated

This is Wes. I think that's an excellent set of goals and I support it. I want people to recognize that it is much more staff intensive because the chance that a change in one specific task has a ripple impacts to change other tests is much higher, so there's much more of a necessity for continually cross-reviewing one test against the other. Nonetheless, looking at the level of testing we've been talking about, I think it's a worthy goal. I'll defer to the Chairs on this next point but, I have a different concern, which relates... just the way I'm wired, I'm concerned about interoperability, but I suspect there's some parallel concerns in other areas. And that is that the 2011 edition of certification criteria for interoperability were best described as trivial. I mean, yes, there was a testing, yes it measured getting a lab result in, but there were no attempts to look at coverage, what are the three or five different kinds of lab results that might likely generate a different code branch in the computer program. And there was no attempt to look at error conditions, which are one of the real determinants of whether two systems can produce an interface that's reliable from the user's point of view. So, at some point, I'd like us to have a place in the agenda to review all of the test procedures modular included, with respect to coverage and handling of error conditions.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So Wes, I think the issue about specificity is part of the discussion that Liz and I had with ONC team leading up to this, so, I totally agree. The question about sort of relationships and so on I think is maybe something that we could talk about in the agenda item about review possible inventory of test scripts, actually should say scenarios, because we could address that issue, right, how many are there and how do they relate to each other? Would that be helpful to you, and Liz, do you agree?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

What I was thinking as I was listening to Wes and so, it's a little different spin on it, but help me clarify please. When I hear you saying that Wes, and we might, and we've got a time thing and Carol, we need your input, too. When I hear Wes talking about integration that's different from these clinical scenario-based testing and I wonder if we should run, this is very ambitious; should we run two concurrent paths, one with persons like yourself and Wes and you know, that clearly understand the end-testing and the integration possibilities and we do it every day here at Tenet and it's a...I certainly can't trivialize it because it is extraordinarily difficult, but it's critical for our systems to work right. What Wes was suggesting is a review of the test scripts, as they exist to look for that kind of testing, I think different from the scenario, but is that a correct interpretation Wes?

Wes Rishel – Gartner, Incorporated

Yes. I think you did a good job of making me recognize that there's this other set of tests out there that are interoperability tests.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Right.

Wes Rishel – Gartner, Incorporated

You can argue that they should be as integrated as the others, so that for example, receiving a lab data through interoperability, a lab datum through interoperability triggers a clinical decision support rule or whatever you want to do. But, I'm concerned at a more fundamental level, more at the unit-test level, that we get to...I don't think anyone expects that certification is a substitute for far more detailed testing and implementation...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

No, no.

Wes Rishel – Gartner, Incorporated

...but the current level... the problem we have is that developers, particularly developers of new product, tend to develop to the test script and if we at least give them one test that makes them aware of a realm of consideration, we have... I think we jog their thinking into... to broader. In the other areas people tend to get running... get to be running short towards the time that they're going to go for certification and will skip anything that's not going to be certified. And for those reasons, I think we can strike a happy medium between trying to be the good housekeeping seal of approval on these, and at least testing the basic capabilities. And I would be happy in supporting a parallel track to work on that.

Carol Bean – Office of the National Coordinator

I would like to also, this is Carol, just a reminder that the rule has not yet come out, the final...the rule hasn't been finalized and so, the criteria haven't been finalized. We on the government side are working on obviously the rule, but also the beginnings of the test procedures based on the input that we have had. As soon as the rule goes out, we can become final, we can begin to share publically, we obviously can't because that signals what's in the rule, at this point. But we can begin to share publically and some of that... I would encourage you not to focus too much on the specific details from the 2011 things, unless there is something you know that no recommendation ever has or ever will be made that they were changed...that they might change, but I think that there's expectation that a lot of the 2014 may well be... represent some changes in there. But, I think it would be premature to do a deep dive on the content of the old test procedures, because we can't yet share what the new ones are going to aim for.

Wes Rishel – Gartner, Incorporated

Carol, that makes perfect sense and I'm not in any way wanting to get ahead of, and either duplicate or make more complicated the work of the other people. And so, it sounds like the Chairs need to just consider this as downstream agenda item. If there were one item of preparation we could do, it might be to, without reference to the specific contents of the rule, describe systematically the kinds of things we think represent a balance between certifying interoperability and not going overboard and staffing that among people on the committee. It would just allow us to be in a little better shape to get going when the final rule does come out.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

That sounds rational to me, how about you Cris?

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Totally agree. I, Wes, really well put.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yeah, we still need to let it out... and Carol, the only question I would have for you, and absolutely respect the fact that we... and don't want to do extra work that will become apparently unnecessary. However, I am worried about timing because once the regs and I don't think we can open that can of worms...

Carol Bean – Office of the National Coordinator

Come on Liz...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

...I'm just stating it. Yeah, exactly. I mean, they're going to come out and people are going to be knocking on the accredited bodies to get them certified. Not quite that fast, so Cris, I think we just should be ready to move fast.

Carol Bean – Office of the National Coordinator

Right, right. But, yeah, but the certified...the certification bodies and the test labs are going to need to get up to speed on these, too. So, nobody's going to be knocking on any doors until everybody's ready. But yes, things are going to move really quickly.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Right. We exchanged some emails last night even about the timing of this whole thing. We had hoped for 18 months, we've talked about this many times, but we all know what the cycle is to try and get things done, and we're going to be sitting on 12. So, we... I don't have to regurgitate for this group that the timelines that are about to be put upon the vendors and the providers of all types are going...and you guys, in trying to create the documents and the tools we need. All of it is very constraining.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Still, we are 30 minutes into our call. I'm going to suggest that we move to start to walk through the first scenario as a way of kind of grounding our conversation here in reality. Does that work for everybody?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Does for me.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Perfect. So, we received three scenarios and Liz you and I talked about it, but I just want to confirm, we were going to walk through the medication management one today?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

We were. Is Scott on yet?

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Scott is on.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

All right.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

(indiscernible)

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Hurray.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

I was talking on mute for about 20 minutes...

Carol Bean – Office of the National Coordinator

I was just thinking sort of who was going to be doing the walking.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, so Scott, if you could lead us through this, would you be willing to do that for the group?

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Sure, not a problem just let me open my laptop.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Thanks.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Okay, so I'll start with the... does everyone have it open? So we'll start at the beginning. The idea with this is to, as we talked about, the purpose is the looking at, as we discussed, the testing from a threaded perspective, being able to take information from one particular scenario, one particular test and pass it on to another.

W

Which one are you talking about Scott?

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

This is the medication management, medication management electronic health record technology.

W

Okay, I didn't hear that and I didn't know whether everybody knew which one we were talking about.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Okay. So, like I said, that was... the initial purpose was just to work with threading information from one particular test to another, and the idea of that, with this particular scenario, is there appears... that need to be removed or skipped for one particular process or another, that's available as well. The testing methodology was basically on the second half of page 3 of the document, has a couple of assumptions. The first, the person that's accessing the system is a person authorized to perform that specified action to be tested in accordance with the certification criteria. Ideally that there are going to be actors that are performing the tests, but it won't actually be the certified conditions or whatnot, they will actually be able to portray them in the testing procedures.

Looking down at the preconditions, it's a typical workflow for medications using EHR in a critical access hospital. And as we go down, the certification that is testing this particular criterion are listed here. This is just an example based on the criterion that is currently listed for Stage 1, and we will update these for Stage 2. The idea with the document being listed here is that you have the criterion listed first, before you actually go into the scenario, so you have an idea that the scenario ties directly back to the, in this case, one, two, three, four, five, the ten criterion listed here. Some will have more, some will have less, but we'll be... I'm interested in receiving input and feedback on the total number of scenarios to be talked about for...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

So Scott that would be why, even though we have a criterion number, citation listed for eMAR that we don't have more because we don't have the final reg yet.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

That's correct. So these, like I said, these are not finalized as yet, but we would be just as an example, we will be looking for feedback to get additional information from this group.

Carol Bean – Office of the National Coordinator

I think right now we're also looking for input on sort of the general approach, I mean, bearing in mind that we can't put the specificity in yet, but the general approach and what needs to be included and things like that.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

This is John Travis, I was late joining so sorry I didn't catch the roll call. But one question I have, and what catches my eyes, the dispensing scenario, and I hope I'm not going into the weeds here, but, considering that unless I'm mistaken, and I only use this as an example. Are we describing things that may be outside the bounds of the certification criterion for the sake of a narrative or is there a possibility that you might, suggest to a vendor that in order to completely show a scenario, you might be showing capabilities that are not explicitly part of certification criterion. So here you might be showing a pharmacy system performing a dispensing act. Is that something that NIST imagines may be in the bounds of the scenario testing in order to make the scenario functional?

Carol Bean – Office of the National Coordinator

John, ONC is doing this, not NIST.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Oh, I'm sorry. Sorry.

Chris Brancato – Office of the National Coordinator

So John, this is Chris Brancato. When I wrote these scenarios, there is a story to be told, I'm a clinician and I tried to make it plausible, more than instructive. Now, with that said, all of the criteria that you see in the certification criteria that's tested, would need to go down the individual criterion test script. So, that's where the rubber kind of hits the road, in terms of what the expectation of what the vendor is supposed to be doing to validate that they've met the criterion.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Yeah, and certainly the test steps themselves have not been elaborated, so, without seeing that, it's... I appreciate that. So, it may just be simply narrative description here to say "here's a realistic scenario," but the test procedures enumeration of the steps would actually drive what the vendor would need to go do.

Chris Brancato – Office of the National Coordinator

That is correct.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Okay, thank you.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Okay, so I'll continue. And we look at the scenario substance. Like I said, site of service is critical access hospital and the users of the systems would include the licensed eligible providers as defined by the CMS EHR incentive program, Interim Final Rule will also include nursing staff, pharmacy staff and physicians. The adult patient is to be admitted to general medicine acute care unit through hospital's registration office, not the ER for general signs and symptoms requiring inpatient admission, for evaluation, diagnosis and treatment. The idea that we were setting up these scenarios to go through a general process, not the emergency department given that the ER may have a different set of criterion and information (indiscernible). So kind of getting to what was talked about before, our scenario assumes workflow is categorized in these three phases: Ordering, dispensing and the administration of medication. They were just used to parse out some of the major steps in this particular workflow and that EHR that would be used in this particular scenario has all the functionality used to meet these three categories and areas.

If you go down to page 4, you see the three scenarios as listed, broken down to the major components that are composed of its... particular portion has been computerized, provider order entry or CPOE, drug-drug, drug-allergy interaction checks, medication list, medication allergy list and then drug formulary check. Down in dispensing, you have eMAR, electronic medication administration, drug-drug, drug-allergy interaction check again and then drug formulary check. And then for the administration, electronic medication administration or eMAR again. List of preconditions: list of current medical/psychosocial problems, an active medication list, current medication allergy list and a current drug formulary list. And now we'll get into the ordering scenario.

I have been asked to kind of read through this quickly. As a result of the provider using...

David Kates – NAVINET – Senior Vice President, Clinical Strategy

On the... this is Dave Kates. On the preconditions, I haven't read ahead, but will specific details of those preconditions be explicitly detailed somewhere?

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Not directly here, there are just examples of a couple of them here, because essentially if we go into too much detail, it may cause some specific changes in the scenario as a whole.

David Kates – NAVINET – Senior Vice President, Clinical Strategy

Okay.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

But...there would if there were additional preconditions that need to be added, we could add those to these scenarios as well to kind of cover other particular issues or problems if need be.

David Kates – NAVINET – Senior Vice President, Clinical Strategy

Gotcha, okay thanks.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Not a problem. So, as a result of the provider using the EHRs clinical decision support functionality, they select several medications from the clinical guideline order set. In addition, the provider orders additional medications not included in the order set. EHR automatically performs a safety check and compares the medications entered against the up to date medication list that was provided previously. The system also performs a safety check comparing the medications ordered and the patient's medication allergy list by performing a drug-allergy check. If any contraindications were found, the EHR alerts the provider so appropriate intervention can be taken before finalizing the medication order. EHR then performs a comparison of the medications ordered against the hospital's drug formulary to identify the medications are contained in the formulary and their drug preference. Once completed, the provider places the order electronically to be used by the hospital pharmacy.

Cris Ross – Executive Vice President & General Manager, Clinical Interoperability Surescripts

So, this is Cris. Just pause at this point, since this is the first explicit scenario component of this document, to just get some feedback about, level of specificity, level of detail, appropriateness, are we missing anything, are there things that should be in scope. I think it would be worthwhile to just take a few minutes to talk about those particulars. Do you mind if we just stop for a just a minute here and walk through this? Does that make sense to everyone?

M

Sure.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yeah, I guess...

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Excuse me, is there any feedback.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I think Cris what you're saying is, if we were in a testing environment, and we were going to use the scenario to drive a look at the application to see if it was capable of meeting the ordering related criteria. That's what this should cover. So, for example, on the previous list, for example, it talks about med rec and that sort of thing. This is very specific to when you order a med, do certain things happen.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Right, and does this include everything that should be included, does it include things that it shouldn't and is it in the right order.

Micky Tripathi – Massachusetts eHealth Collaborative

So, this is Micky. I've got one question. Because I think the terminology is really important and consistency in terminology is important and as I look at the preconditions, in the first bullet, I'm just wondering why it says a list of current medical/psychosocial problems instead of just saying a problem list.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

That's a good question Micky.

Chris Brancato – Office of the National Coordinator

Micky, this is Chris Brancato, that's a great point. We'll make sure that all of that syntax lines up.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yup.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Very good, is there anybody else? I know David Kates you haven't spoke up yet, but I know you've come to the...you'd let us know that you'd come to the meeting.

David Kates – NAVINET – Senior Vice President, Clinical Strategy

I did.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

David, do you have any comments about this? I don't want to put you on the spot, but usually you're pretty insightful about this stuff.

David Kates – NAVINET – Senior Vice President, Clinical Strategy

I don't have any insightful comments, but (laughter), always have comments. Honestly, I think I need to digest it. Along the lines of what Micky just said, and I did raise a question earlier, the one related to sort of what level of specificity around some of those preconditions. I do think we're going to have to find a balance so that while this is more of a conceptual framework for... and I missed the preamble in terms of whether this is to drive the development of the test scenarios that are going to be used by the certifying bodies or whether this is really instructional to vendors or sort of who the audience is and then what the next level of detail beyond this thing is. So, just figuring out what purpose it serves and then appropriate level of detail, whether it's in this document or whether it's in subsequent documents that are generated as a result of this framework. So, that's just reaction, not necessarily a to do or back to anything that's insightful. But, that's sort of how I read it.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yeah, I was going to say, Cris, do we need... I mean, Scott can you give... in order to get David on the same page with us, is there a Readers Digest to answer his question?

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

And who's the audience for this, is it...

Chris Brancato – Office of the National Coordinator

David, this is Chris Brancato. I think the intended reader and user of this document would be a TL, a testing lab and the vendor.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

This is John Travis. I think I'm with David and I'll use an example. You have the term in there, clinical guideline order set, which is going to... I can guarantee every vendor has a conceptualization of what that is, some of them might view that as a concept of a... as CMS and the recent condition of participation reform regulation defined a predefined electronic order set. Other vendors might think that's just an ordering convenience, so, I think there is a need for a manner of a glossary when you use terms like that, because what you don't want to have happen is that a tester has an expectation and the vendor has an expectation, and they're off page. Because you could get hung up in, "now wait a minute, that doesn't look like an order set to me," and the vendor's going "what do you mean, that is an order set." It's a very loaded term, right there, and it's hard to avoid that, but, maybe definition of that. So for example, is that clinical guideline order set an actual pre-defined electronic order set as CMS might define it, in the regulation, they have a good working definition there. Or is it something that is pretty open for the vendor to interpret in most any manner of a structured multi-select list is an order set. And Liz, you know our system, you know the difference...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yes, I have...

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

...between a power plan and an order set.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Absolutely.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

So, that would mean very different things from a "what do we go do to show it," so that's one suggestion. And then, perhaps being a little more explicit about some of the set ups of, although in fairness, maybe that was dealt with, about the provider being in a particular healthcare role.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Well I think... so, there were lots of comments there John, and all very helpful. I think the challenge in reading these, and we haven't talked about it yet, kind of is how we go forward. The question that Cris posed earlier, do we need five scenarios, or fifty and of course as we were talking last night, I go towards a smaller number, because I think it will get overwhelming for lots of reasons, for everybody; testers, providers, ONC and so on. But, my inclination is, I think what we would hope for is if we could get to a very limited number of service locations as I might call them, or places where we render care and then we would try to get through as much as possible. Remember what we're trying to do here, but beyond...of course we have to have the definitions so that somebody can actually use the scenario in a helpful way, is we're trying to make sure that we're testing for clinical relevance. Because we hit the wall a few times last time, based on our very hurried up sort of getting ready for, what we were asking people to test against clinical scenarios that were not real. And we heard a lot about it.

And so that sort of started us thinking about wouldn't we engage our advisory groups if possible, to help establish some clinically relevant test scenarios so that, you've heard Joe talk about, you've heard me talk about it, you've heard Dr. Halamka talk about, we're testing against drugs or scenarios that just simply do not occur in the real life. That was as much a driver as trying to get the definitions right.

Scott Purnell-Saunders – Program Analyst at US Department of Health and Human Services

So, I guess I have a point here. My question would be is the request and if we are going to use even terms that aren't necessarily as specific as a clinical guideline order set, that we add a glossary to some of these scenarios so that everyone kind of knows what exact terms are being used and what exact reference we're using related to these. Would that be helpful?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

I think it would be very helpful.

Carol Bean – Office of the National Coordinator

I think that that is an excellent suggestion and I'm always for terminology specificity, but we also need to be very aware that this is going to have to hinge on the wording and the language in the rule, and some of that is specific. But it also needs to be...to avoid a level of specificity that rules something out. And so...

M

Agree.

Carol Bean – Office of the National Coordinator

...we're going to have to have some flexibility in meaning, or else we will exclude certain either situations, people, pilots; whatever, that really should be included. The intent is not to exclude, but really to include and to... but the point is actually kind of orthogonal to this, which is, as Liz said, we're really trying to make this be clinically relevant and if it ends up that the specificity is an issue, we may be to where we just can't do this, under these circumstances. Because you've got to come down somewhere, and so, if we're not able to figure out and translate and do that. So that's just something I'm listening to and watching for, to be sure that we do have a level playing field and that everybody can play with these things. If it's not going to be helpful, then, you know, it's not going to be helpful.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

This is John Travis. I absolutely agree with that and I wasn't trying to suggest anything more than really just that Carol, that you don't create such a perception by the use of terminology in the tester's mind and the vendors mind that you run into that situation. And, I know that's hard, but, the terminology in a simple glossary may help, that allows for an expansive understanding of it that honestly at some level there's the vendor explaining to the tester, this is what our system does to do this, and the tester goes, okay.

Carol Bean – Office of the National Coordinator

Right and of course the test labs will also have, in addition to all the public comment that we have to have on our tests and testing procedures and all that, the test labs will receive extensive training on this.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Yeah.

Chris Brancato – Office of the National Coordinator

John, this is Chris Brancato. I think it bears repeating that the ultimate language that a vendor has to certify to is contained in the individual test script. Make sense?

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah Chris, just to be clear, can you make a distinction between the script and the scenario, just so everyone is on the same page.

M

Correct.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

...and making that description.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

And we're not seeing that Chris, yet. We're not seeing the script yet. No, I understand.

Chris Brancato – Office of the National Coordinator

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative

This is Micky, I've got another question.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yes, go.

Micky Tripathi – Massachusetts eHealth Collaborative

And maybe it's related to that comment that we just had about the script versus the scenario. So, but I'm just wondering about, and I think Wes was sort of touching on this as well, is there sort of an insidious effect of creating these... over specifying some of these scenarios that you get product design starting to follow the test? Like teaching to the test? And in particular, so I'm not a clinician, and I certainly understand that as we walk through, doing something like this versus the unit testing of each component, that completely makes sense to me. So, I'm just trying to figure out what's the appropriate balance here, and how do we sort of strike that? And I can see at a high level, it completely makes sense to say, "Got a high level workflow, ordering, dispensing, and administration." That makes sense to everyone and it's hard to imagine how you would get those things out of order.

But, then we go through here, and again, I'm not a clinician, but it's not obvious to me, for example, that you would do a formulary check after a safety check, for example. But if I follow through this, it says the EHR does, then, and it does say "then," it performs a formulary check. Now maybe I'm just...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

No, I think Micky you're right, and as clinician I can tell you, I think you're exactly on and it's a great point. And what probably needs to, and someone would suggest an amendment, that we could sort of think of as we go forward, maybe in lieu of putting an order, or using the word then, the next step needs to include these three components and we don't specify the order, for example. Would that satisfy your need, because all three things need to happen, or else...?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

...but we don't have to specify in which order, so that we don't necessarily, like you said, drive the functionality. It's not that we... because as clinicians, we could argue all day long about which one happens when.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

And in some instances, it may truly matter, but in many instances, we would not want to go to that level of specificity.

Micky Tripathi – Massachusetts eHealth Collaborative

Yup. That makes sense to me.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, this is Chris. I know we've had conversations in the Implementation Workgroup and elsewhere before about the idea of encouraging usability, right, and should we do something around having an opinion on some guidance about making systems useful, I think we have generally looked at that topic and walked away from it, because it's simple too hard to certify usability, right? And I think what Micky raises is a fantastic point around usability, you know, one application may want to do it one way versus another. I also...it seems to not make sense to me, anyway, also to do the formulary after you do the safety check, right, because why would you want to do the analysis of the drug and then say "oh rats, I can't dispense it," you'd want to find out what was available first. But, different applications may want to do it different ways.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Or the things may happen concurrently frankly and so trying to imply a very specific timing, when the two activities happen concurrently. I think the point is taken and as we build these... or review these scenarios, we should try to use as one of our guiding principles that we not be so specific, and particularly around timing and other things, that we drive a vendor to design their system to meet the test.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So have we gotten everything out that we need to around this specific ordering scenario and if not, let's get some final comments, and then go to the dispensing scenario. Any last comments on ordering?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Cris, I would just tell you that my only concern is that... and I know there are other clinicians on the call, I'm kind of like David was commenting, I need to read it very carefully and make sure that I can really react to making it as open-ended as possible, while following what would truly be the right clinical set of guidelines. And so, it's hard to just read it and not... because I would pull back from the group and do these and I think we will at some point, when we get to the assignment part, and really walk through them. We have to think that we're setting up some guiding principles here.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, that's fine. I think we're doing... Liz, great point, I think we're doing kind of a rough draft walk through right now to just check reality of this and get people to start thinking about it. Why don't we push to the end of the dispensing scenario and administration scenario and then we can get to our agenda items about assignments and our next steps.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Okay, so I'll keep going.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Thank you.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

In the dispensing scenario, the EHR alerts the pharmacy that medication orders have arrived for dispensing, order's reviewed and additional safety checks are performed. Pharmacy personnel or robotic dispensing equipment select the correct drug in the formulation as ordered. Orders are verified by pharmacy staff for accuracy. The medications are noted as dispensed in the EHR and delivered to the unit for administration. This dispensing, I think the addition of the robotic dispensing equipment is kind of optional and that we can probably generalize that a little bit further, but it's the idea that, however it's dispensed in that particular pharmacy, would ideally be...

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So this is Cris. Scott, I've just got the question about, from a process standpoint, the sentence that has about pharmacy personnel or robotic, etcetera selecting it, that's not an activity that would happen within the EHR, right? So this is one of the first items that was kind of a workflow item that is not subject to EHR content or flow.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Cris, it might be, because what often happens is you release it in the Pyxis so to speak, or some other thing, so I think we just have to modify it a little bit.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Okay.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

And then I had the same idea, but a little different and that would be when you say deliver to the unit for administration, unless it's delivered in an electronic format, we also wouldn't catch that, so I think we're thinking the same way.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, my point was not that it shouldn't be in here; I think for completeness, it makes a ton of sense. It might make sense; I'd love to have a little discussion about this, about whether we would differentiate. These are things that are in the scenario that need to happen in the way that it happens, you know, holistically, including people and technology and other processes. And then the other is, and these are the specific pieces that would be subject...that would be related to specific test scripts, that would be used for certification.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Right and this is John Travis. That's where I was going with my comment earlier about seeing dispensing in here, simply that. You've made my point.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yup.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So maybe we may want to think about how we call that out, maybe its italics, or whatever.

Carol Bean – Office of the National Coordinator

And the good news is Cris, is we can assign this to a group and we can come back and bring our modifications for review.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Got it.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Scott, do you want to do administration?

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Any other questions?

Carol Bean – Office of the National Coordinator

I don't think so; I think we can finally go to....I think...

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Let's do administration, yeah.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Administration scenarios. As medications arrive on the nursing unit, the nurse reviews the medication administration schedule for the patient using the EHR verifying that the patient is to receive the medication according to the medication schedule. Before administering, the nurse uses the EHR's assistive functionality and performs the following other checks, and now we can probably put in no particular order, possibly, since we discussed it earlier, first...oh not first, I'm sorry, identifies the patient as per hospital protocol. Verifies that the medication is identified for the patient and that the medication matches the original order. Verifies that the dose matches the medication order. Verifies the timing of administrations that they match the order as well. Verifies the route of administration matches and after performing these checks, the medication is administered and recorded in the EHR as such, in adherence to the original order.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

So Chris and Scott, the only questions I had about it was we don't have the final rule and this is kind of back to Wes and Carol and several people have made comments, about there's no question this the right. I mean, we could go through some other writes, but, I... when we don't have the final rule, we may have to do this pending exactly what does the rule say about assistive technology versus accomplishing this, you know, what's actually required, let me just cut to the chase. Because we know what the proposed rule is, but we don't know what the final rule is.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Yeah, I think all of us kind of approached that from that particular stance, so we understand that this is in progress and in draft form and that we can make adjustments as need be, once everything is final.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Exactly.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Good conversation. So, anybody have any additional comments on this scenario, if now, I think we want to move to our next agenda item, which is, where do we go from here? Any other comments? In general or about administration scenario. If not, why don't we go back to our agenda here, which was, now that we've walked through one of these, and we had a good preliminary conversation about purpose of this, let's have a brief discussion about the possible inventory of test scripts, so we understand how big this is, and then think about how we might assign work.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

The one question I was going to ask of the staff is, have you... have they, I know you're on the phone so I don't want to talk about you in the not present condition, have you proposed a list that we might look at or do you think these... have you thought about that, can you give us any insight so that we're not shooting from a blank piece of paper.

Carol Bean – Office of the National Coordinator

Well, we were hoping... I mean, yeah, we've got dozens of possibilities, but part of it is trying to trim that down, trying to see what... obviously, we've got target times that we're shooting for, and I think we've got...we want to get these right. I wasn't aware that you had come up with some numbers of, like a smaller set versus a larger set. We thought it would be most helpful to kind of get these out there and get your sense of these and then based on this kind of thing, how much more detail do they need, how much less, whatever, so that we have a sense of what the level of effort is both in terms of producing these things and reviewing them. So, I think we could probably target, you know, in the half dozen range. I think it would be good to have some very generalized ones like a patient record kind of thing, and then, just sort of, what are the big ones that we need to get covered. So, we wanted your feedback on that as well, and partly because we don't want to spend, I mean, to be very candid, it doesn't make a lot of sense for us to spend a lot of time developing these without a little bit more feedback.

Chris Brancato – Office of the National Coordinator

This is Chris. Is the universe of the scenarios that we're looking at...I mean, obviously the total universe would be all the testable criteria per meaningful use. Is there a guiding principle in terms of the ones that require this level of scenario, based on either ambiguity or the usability aspect or some other thing that I think... rather than inventory it first, figuring out what the attributes are and then...

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Right. Well, this is Cris Ross. Let Liz and Carol and others speak up, but I think the goal here was to say, as David says, there's a script for everything and the purpose of the scenario is simply to put a thread through those beads where they need to be in a particular order or particular context, where the script alone is insufficient. And that's all we're attempting to do. So, I think what we want to do is to figure out are there places where we know that a test script or series of scripts standing alone just doesn't do the job or didn't do the job in Meaningful Use 1. And I think, especially people on the call here who are vendors, could give us some terrific feedback on that.

Carol Bean – Office of the National Coordinator

And I would agree, and I think that's an important distinction Cris, to say, sort of a where are the pain points, because everything theoretically is a bead...

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Right.

Carol Bean – Office of the National Coordinator

...and should be on a string somewhere. But where were the ones that just really either seemed ridiculous or were painful.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

I would say maybe John and Andrea, that is kind of where we were going was, as a vendor there was a set of things that we heard consistently from you guys, both in this workgroup and outside of this workgroup in panels, that just seemed like you were retesting the same basic thing over and over. Which was one of the reasons why medication management rose to the top very quickly; because there are just, across multiple criteria or requirements, it all got to a single process. And that was our hope, that we could gel those. And I'm like you David, I mean you could create a scenario for anything, but we could go way over the top.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Right, and I think it would be helpful to specifically say was there an instance where we could find pairs of scripts where things just, you know, it didn't make sense. Perhaps even the instance where when you tested against one script, you had to go left and when you tested against an adjacent script, you had to go right in a way that was frustrating or inconsistent.

Andrea Sim – RelayHealth – Vice President of Product Management

This is Andrea. I think the medication management, you called that out, but that was definitely one of the pain points. The other ones were some of the CCD exchange or the CCD ones.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Amen.

Andrea Sim – RelayHealth – Vice President of Product Management

Yeah, those were...they were very inconsistent and it would have really helped to have a single set of, or kind of threaded, as described, set of data for those. Lab was only one...I'm trying to...there might be some validity...I mean, that was a painful one, if that had to go across multiple scripts for Stage 2, that would be another.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Yeah, we had multiple... this is John. I absolutely agree. I was thinking two things; one was anything like the electronic copy, the summary of care, the discharge... any of the discharge materials, those all lend themselves to being built out of other scripts. So, somewhere along the way we were entering or creating data that would have fully populated those, yet we had to distinctly populate those just within the bounds of the test procedure for electronic copy. So, that's a pretty unnecessary task and you're creating other opportunity for, quite honestly, data entry error or clerical error that you don't necessarily need to create. We've proven we can enter demographics; we don't need to continue to enter demographics five, six times over.

Andrea Sim – RelayHealth – Vice President of Product Management

Yup.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

The other thing that strikes me is, to the degree it can make sense, is to build upon things that you would think naturally occurring at a similar phase of care. So for example, another way to construct it might be to put... now, actually the criteria, that's one of the things we liked about consolidating clinical reconciliation. But, the problem list, documenting allergies, documenting or doing medication reconciliation upon receipt of a patient from transition of care, are all things that naturally might occur at a similar point in time, possibly even by the same kind of clinical role. So to build upon a commonality of timing from a clinical workflow standpoint, would also help, be apparent.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

That sounds like some of the beads that we want to tie together and...

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Exactly.

Andrea Sim – RelayHealth – Vice President of Product Management

Yeah.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Things like we want to figure out to the earlier point of whether its transitions in care or interoperability, but that the CCD is an example of a scenario that we want to create around information sharing and care coordination, that the things that John just articulated probably fit into another scenario, than those described.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yeah because that's exactly what I wrote down, John, was transition of care. What would be the common components of the transition of care that would cover multiple criteria, much similar to what Scott did in this medication management, where on like page 3 it started talking about what criterion would we cover with a single task.

Chris Brancato – Office of the National Coordinator

So Liz...

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

No, I was just going to offer... sorry, go ahead.

Chris Brancato – Office of the National Coordinator

This is Chris Brancato. So I wrote two additional scripts, one for a comprehensive inpatient scenario and one for a comprehensive outpatient scenario to cover the eligible hospital and the eligible provider. So, I think if you get a chance to look through those, I think you'll get at least a conceptual idea of how those things might fit together, to address some of John's concern.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yeah, so that kind of speaks to phase of care and/or specific service location...and I did, I liked the fact that when I looked at those, that they covered...if you talk about the EP, this is where we'd go and we pick up a lot of those things. If you talked about the hospital provider, this is where we go.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Yup.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yup, agree. And Andrea, does that get... of course, we still... I don't know whether Andrea that would get your lab stuff.

Andrea Sim – RelayHealth – Vice President of Product Management

I think so, yes.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

I think so, too.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Yeah, I think we just want to make... explicitly make sure we address that.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yeah. And then from the e-Prescribing stuff, Dave or Cris, I mean, is that something that's going to fit in here somewhere?

David Kates – NAVINET – Senior Vice President, Clinical Strategy

I mean I think it can fit into that scenario that we just did.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

...walked through, yeah.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Yeah, I think, and with a couple of extra additions we can add that to that one.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah.

David Kates – NAVINET – Senior Vice President, Clinical Strategy

Yeah.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Okay.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

You could add medication reconciliation and sometimes e-Prescribing happens as an outcome of that, so discharge reconciliation.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Right, that's why I was debating whether you put e-Prescribing and med rec, which med rec was listed on meds management, which it is part of that, but it's also part of transition of care. But, we'll figure it out.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

That's good news.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

The only comment I would make about including e-Prescribing in medication management is, a module could just be e-Prescribing, right? And so you would not want to burden the e-Prescribing app with the comprehensive med management.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

But...

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Yeah, we're not.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

But Cris, I think we agreed, but I want to make sure that this... a typical. Cris, I think we agreed that even that as a modular vendor, or even as a vendor who wants to have a separate certification for a specific module, you wouldn't be asked to go through a complete testing scenario...

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Yeah.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

...you would be able to go back to the unit-based testing type of work.

Carol Bean – Office of the National Coordinator

Absolutely.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Let me go back to this. This is not a substitution; we're going to still have those in there as a test as well.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Well and I think though that Cris's point is well taken that we need to keep reminding ourselves as we report back or make recommendations, that we bring ourselves back to that. We're not trying to impose this on all.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Well and there might be, this is John again. There might be some things that naturally are only in isolation, I mean, it's not a very natural part of clinical workflow to go submit reportable syndromic data; that might be a machine process. So...

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Exactly. Or do your immunization or whatever, all those things.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Right, and that's one more point I wanted to add to this, because we've been designed the scenario so that they're composed of several small modules that has something will not... or does not have one particular piece that it can be taken out. I mean we talked about this or Carol talked about this a little bit in the overall explanation document of this, but, just to kind of reiterate that point. It may not have to go through every single piece of the scenario if it doesn't have to.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, I think it would be unlikely that we would find very many cases, this is Cris, where there was a scenario that was needed for a module, right? I think that most of the scenarios would apply more naturally to a comprehensive EHR. However, there may be a place where we really do want to write something like, let's say a scenario for e-Prescribing. I'm just saying, let's not bury it in the context of a larger scenario.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

That's a good point.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

All right, so we've heard...I haven't been keeping clear count, but I think...can we just walk through orally again what was everybody's notions about what the possible scenarios were. We've got inpatient, outpatient, medication management and reconciliation.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

You've got kind of a phase of care Cris, so that things that could naturally happen at admission, things that could naturally happen at discharge or transition of care, are definitely things that lend themselves to that.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

And then there were the items related to CCD creation, other activities. Does that fall into that scenario John or do you see that as separate.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Umm...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

He's talking about transition of care; I lost you a little bit.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, transition of care.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

I think that that can be part of the transition of care, but built up out of the...that might define your grouping. So you look at what data winds up needing to be required for the consolidated CDA that's the transition of care structured document, you're going to have clinical reconciliation, you're probably going to have med list...so, not suggesting the entire list, but those things that are framed by the requirements so you can fulfill them. And then it doesn't have to be a distinct thing, it could be the transition of care scenario.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Andrea, do you agree with that, I don't want to put you on the spot, but, as another vendor on the call.

Andrea Sim – RelayHealth – Vice President of Product Management

I'm sorry, can you repeat the question?

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Sure, so we were just talking about whether the transition of care and creation of consolidated CDA would fall into the same sort of broader transition....

Andrea Sim – RelayHealth – Vice President of Product Management

Oh yes.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

...scenarios that John was describing.

Andrea Sim – RelayHealth – Vice President of Product Management

Definitely, definitely, yeah.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Okay. So what else do we have, I think that's five, correct.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Well, what if we started there Cris, I don't know if Carol and their group have other suggestions, but just the three we have are quite a start. And I don't know Carol and Scott and all of you folks, have you already begun work on these other kinds of concepts or... I know you were kind of waiting for some feedback from us on the first three, which we haven't given you in totality.

(Indiscernible)

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Yeah, I think our approach was to really use the three that are currently listed as a starting point, and then as we receive feedback, if it was necessary to add, a few more, several more, was there. I mean, there was also some discussion between our...individually that we want to describe a limit as much as we could, like there was no point in trying in trying to develop fifteen or twenty different scenarios because, we realized that people would then end up starting two tests directed to the scenario...I mean, to build to the test, instead of keep building out... (Indiscernible)... overall development. So, I think indiv- like Carol and I were talking, maybe like five or six total, but, we're open to suggestions on that too.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

This is John Travis, can I ask a stupid question, because inevitably if you were to take the five we've suggested, there would be overlap.

Carol Bean – Office of the National Coordinator

Yes.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Are you necessarily trying to exclusively only include criterion in a given scenario or...

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

I think my perspective is that overlap is okay.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Okay.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

And...(indiscernible)...between that, but it's you're not trying to test directly in a vacuum, because you want to show that the information is passed from one to another.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

Yeah.

Carol Bean – Office of the National Coordinator

But the point is not to, you know, have a scenario for every possible situation...

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

No. In order that the vendor necessarily comes in and goes, I want to do scenario A, D and F, but not the others...

Carol Bean – Office of the National Coordinator

Right.

John Travis – Cerner Corporation – Senior Director and Solution Strategist, Regulatory Compliance

And that's where I wanted to make sure we weren't headed. I don't think that would be good design.

Stephen Palmer – Texas Health & Human Service Commission

Hi, this is Stephen. I have a couple of related questions. Is it the intent then that each unit-based criterion should appear in some scenario?

Carol Bean – Office of the National Coordinator

No.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

No.

M

No. I wouldn't think you'd want to force that again. Kind of the example of something like syndromic surveillance might be so out of sync to a care process, and even typically happen asynchronous to any individual care, that that'd be...you just...I wouldn't want to see us coerce it into a scenario just for the sake of it.

Stephen Palmer – Texas Health & Human Service Commission

So then would, in order to pass certification then, would a product need to pass each of the individual unit tests and pass all the scenarios that include some set of those unit tests.

Carol Bean – Office of the National Coordinator

The intent is not, but if it does pass... if the individual unit can be tested completely in a scenario, then that would suffice. But, one of... actually having been on the other side, talking in very much detail with the labs and some of you have too, I'm sure. The unit...the redundancy that so many people find annoying and all, how many times do I have to show this? Many of the labs say that it's only upon multiple, you know, kicks at that cat that they're finding out, because they're coming at a given functionality in different ways each time, that repeated testing actually manages sometimes to tease out problems in some kinds of things. So, I think it would be unlikely that where there would be concern that the...we do not want to tie the hands of our test labs and our testers, that if there is some concern, that oh, well we passed it in the scenario, that's it, you can't test it again or you can't test it alone, you know, that sort of thing, to ensure because of safety and functionality and consumer issues and stuff like that.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Stephen, I know when I was looking at these, I guess, and I'm going to try and verify this with you Carol, I thought that if I were a vendor and I were testing and I looked at the medication list and it listed several things under 170.302 and 304 and 314, that if I passed the scenario, I would also pass all those criteria for certification. Is that a fair assumption or a bad assumption?

Carol Bean – Office of the National Coordinator

That would be the goal. But it would not then... if there was some concern, and that's what I was just trying to say, it's up to the test lab, these scenarios are not required, they are kind of... they're nice to have. But, a test lab has a concern about a particular feature or function; they need to be able to look at it in greater detail. I mean, we want them to.

Stephen Palmer – Texas Health & Human Service Commission

So I guess then, would that mean that a given test lab could opt only to use the individual certification requirements and not the scenarios at all?

Carol Bean – Office of the National Coordinator

Realistically, no, they couldn't because they're going to have to show proficiency.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Well, and then don't we get a little bit too back to Wes's original point around interoperability, too? I mean, I realize we're not there yet, but part of this was also talking about beginning to make sure that these things sort of worked their way through. It doesn't give us interoperability to other applications, but it's a step in the right direction.

Stephen Palmer – Texas Health & Human Service Commission

Okay, then explain to me what the flexibility at the testing body level would be, in terms of use of these, if they would have to do some but not necessarily all.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Ask a question.

Carol Bean – Office of the National Coordinator

It would have to be able to do all, but... part of this program is designed to be flexible. We cannot anticipate today, exactly what products and what types of things are going to be showing up on the doorstep of a test lab next March. And so, we need to be able...that's one of the reasons for the tinker toy things, but the lab and the certifying body have the ultimate responsibility. They're on the hook for these products, for the certification and certifying the functionality and all that kind of stuff. So the test lab can't just willy nilly say, I'm not going do those, they have to be able to do them all. But the point of the flexibility is, if they have a concern about something, they need to be able to follow it to the end, follow... if they see if you want to keep the beading and threading kind of thing, if they see a loose thread someplace, they need to be able to tug on it and see whether it unravels.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So, this is Cris. I'm just observing the time. We're into our public comment time and run out of agenda. I'm going to make the suggestion that Liz, please correct this if you disagree. I'm going to suggest that what we want to do in terms of assignments to team members, is to ask folks to read through the other two scenarios and to continue the same sort of thinking we've got. And then in our next meeting, for us to pick up the items of, to get ONCs view about what the next set of scripts or the final set of scripts should be, and to continue to push through them the way we did today. Liz, does that match? I think that's what we've talked about so far.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

I agree. My concern is that what we didn't have time to do, which is absolutely understandable and the conversation was well worth it, is we didn't assign an owner for each script, and we didn't look to see if we needed other clinical expertise. So my suggestion is that we ask the group for their permission to make assignments, so we have a lead on each one and then we can work with the group, if that's okay with the workgroup.

Carol Bean – Office of the National Coordinator

Can I make a friendly amendment Liz, and that would be, I mean, if everybody agrees that at least these three... I'm thinking we're targeting 5-6 total and if everybody agrees that these are three core types of scenarios, then that would make sense. But, that assumes that people are in agreement on that.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So Liz, if we really are going to be walking through a total of I think 5 on our current list...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yes.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

...I wonder if we want to have workgroups or if we just want to do these as a group as a whole, to go through that first set of five. Just thinking out loud.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

I don't know that I can do... my concern is really digging into it in a way that would be... that we won't spend all of the time going through clinical ramifications of what we're saying. Maybe what we'll do... here's what we'll do Cris. We will push the next meeting with everybody in the group being assigned to look at all three, and then I will take responsibility to make sure from a clinical perspective that we get the clinical input ahead of time, so that as a group, we can... obviously it would be most helpful to provide it to the whole group ahead of time. The reason we'd like this change is because... and those who are not clinical may go, whatever, and those who are clinical can go yes or no. Is that fair?

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, and I'm glad you were here, but I'm sorry that for instance, Joe Heyman wasn't here, because he's always really good at raising his hand and saying, guys, real doctors don't work this way...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

And that's the kind of thing I was thinking was that... I'll drop Joe a note and just say, you really need to look at the EP one and you need to get... you know what I'm saying? I can really look at the provider one... and I know Andrea and John and others can help me. I mean, not that we have to meet separately from the group, but we really need to look at them.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yeah, I think that's fair. I think we probably have more inpatient representation than outpatient representation today, I may be wrong about that, but...

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

No, I think we may want to make sure that Andrea and Joe and then you and I need to talk about do we need others to look at it. I mean, I can certainly have people here look at them and get us feedback if that will help.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Of course.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

And I'm sure others can do the same thing as well, it's not just me.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Of course. All right, so with that I think our next step, I think all we want to do right now Liz is just to make sure that we have our next meeting scheduled and it's on everyone's calendar and then go to public comment. Do you agree?

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Agree. MacKenzie.

MacKenzie Robertson – Office of the National Coordinator

Yeah, this is MacKenzie. We actually have several meetings already planned out and they should all be on everyone's calendar; the next one in the list is Thursday, July 12 at 10 a.m., and then we have another one on August 2nd, August 9th, August 13th, August 23rd, September 5th. So, we do have quite a few meetings on the books already.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So we've got the one next week and then we've got a gap between the next meeting. So, if next week we can really finish the work of making sure we understand what our approach is and the scope of things to be talked about and assignments done, I think then, Liz, we could have folks go away and do a little bit of offline thinking before we come back together at the beginning of August.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

That's a great idea, I like that approach.

Wes Rishel – Gartner, Incorporated

We have one next week you said? Oh yeah...

MacKenzie Robertson – Office of the National Coordinator

We have one Thursday, July 12th at 10 a.m.

Wes Rishel – Gartner, Incorporated

But that's two weeks from now.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

That's two weeks, yes.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

It's a week and a half.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

I'm sorry, sorry, I'm past next week already.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Yeah, me too... because I'm off next week and I was going, I don't remember that,

Wes Rishel – Gartner, Incorporated

All right.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

Thank you Wes for that correction. Keep us straight.

Wes Rishel – Gartner, Incorporated

Always glad to be double committed.

(laughter)

MacKenzie Robertson – Office of the National Coordinator

Are we ready for public comment?

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Yes, can we go to public comment please, MacKenzie. Thank you.

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the lines for public comment.

Public Comment

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do have a comment from Missy Willoughby.

Missy Willoughby – Healthcare Management Systems

Might there be a set of test scripts defined as constituting the base EHR functionality?

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Carol, can you answer that?

Carol Bean – Office of the National Coordinator

Mary Jo, MacKenzie, do we respond to the comments?

MacKenzie Robertson – Office of the National Coordinator

Yeah, anyone can respond to the public comments.

Carol Bean – Office of the National Coordinator

Okay, just typically we haven't done that. We will take that under consideration. Thank you.

Caitlin Collins – Altarum Institute

There is no more comment at this time.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

All right, unless anyone else has anything else to add, I think we are adjourned for today and I hope everyone has a terrific Holiday week, if you're taking off any time, and a great weekend.

Elizabeth Johnson – Tenet Healthcare Corp. – Vice President, Applied Clinical Informatics

And here, here from me and thanks to everybody for taking your time, especially when we're so close to the holiday weekend. Take care, everybody.

M

Thank you, bye.

Scott Purnell-Saunders - U.S. Dept. of Health and Human Services - Program Analyst

Thank you, bye bye.