

**Implementation Workgroup**  
**Draft Transcript**  
**July 25, 2012**

**Presentation**

**MacKenzie Robertson – Office of the National Coordinator**

Good morning, everyone. 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, and the call is also being transcribed so please make sure you identify yourself before speaking. I'll now take roll. Liz Johnson?

**Elizabeth Johnson – Tenet Healthcare – 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**

Robert—oh, hi, Cris. Robert Anthony? Kevin Brady? Anne Castro? Simon Cohn? Tim Cromwell? John Derr? Timothy Gutshall? Joe Heyman? David Kates? Tim Morris? Nancy Orvis? Steven Palmer? Wes Rishel?

**Wes Rishel – Gartner, Inc.**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Wes. Kenneth Tarkoff? John Travis?

**John Travis – Cerner Corp.**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, John. Micky Tripathi?

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Micky. And Gary Wietecha? Is there any staff on the line?

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

Scott Purnell-Saunders.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Scott. Okay, Liz, I'll turn it back over to you.

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

Great. And I know that Cris is here as well. I think this morning, what we're really going to do is try and get through the outpatient scenario and—and certainly get into the inpatient scenario. We have lots of comments from Joe Heyman and I'm hoping he can join us. Um, also Cris, I think you may have joined just a couple of minutes after we did, and Micky is in a car, so as we take comments, we need to ask our uh, workgroup members to sort of ref—kind of give some definition around what they're talking about so we can follow each other's conversation.

**MacKenzie Robertson – Office of the National Coordinator**

And Liz, this is MacKenzie. It looks like Joe may have just joined.

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

Great. Excellent. Um, Cris, comments on how other sort of, you know, kind of what I was concerned about, we also have another topic that we want to get to towards the end of the call and we may do it on this call or—or, you know, as others related to the issue around the fact that we have meaningful use standards for Stage 2 coming out, we hope within the next 30 days or there about. We—this group has specifically recommended on two occasions that we be given an 18-month window following the pronouncement of those rules so that we could have time to prepare, and I don't need to go into everybody understands the cycle of software development testing, implementation, getting it to our—the customer, the customer being, for example, in my place, John, being the vendor, me being the customer, getting that into our systems, training on it and using it, and at this point, for the September, essentially September set of—of regulations and an October 1 of next year requirement to be in compliance, we are now 13 months out.

So, we want to have a discussion about that. I think that's a pretty good description, and so, we will try to let—leave some time I think for that, and I know that Ken Tarkoff would like to join for that. So, when we get close, Cris, I want to let him know that we're having that discussion.

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

Yeah, that's—that—that sounds good.

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

Yeah. And with that, I'll turn it—Cris, other comments so we can get started or direction to us or—

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

No. I don't think so. I apologize for coming late. I had a customer call that was very difficult to step away from. So I think we should just go back into the inpatient scenario, see if we can finish that and then move onto the outpatient scenario.

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

I think it's the other way around. I think we want to go—

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

Oh, yeah?

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

To outpatient, is that right, then inpatient?

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

Yep. That sounds—

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

Yep.

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

Just fine.

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

Yep. And Joe, did you join us? So, MacKenzie, do you see him online? Is that what you're seeing?

**MacKenzie Robertson – Office of the National Coordinator**

Yeah. It looks like he hasn't joined the—the conference call, but he's logged into the computer.

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

Okay. Well, I guess then, Cris, we just get started.

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

Yep.

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

My suggestion would be we would just start at the top and kind of look at Joe and others' comments and proceed in that direction. Do you want to start us, or do you want me to start us?

**Wes Rishel – Gartner, Inc.**

This is Wes. When was the material sent out?

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

Yesterday.

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

Yeah.

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

Um—

**Wes Rishel – Gartner, Inc.**

Okay. I'll find it. Thanks.

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

Okay. I can tell you a time in a second. MacKenzie, do you remember what—because I remember seeing it. I'd say the scenarios went out at 2:39 from Scott Purnell-Saunders.

**Wes Rishel – Gartner, Inc.**

That's the Implementation Workgroup, right?

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

Yeah.

**M**

....

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

Scott, did you update those scenarios at 2:39, and those would be the most current ones?

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

Yes.

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

Okay.

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

This is all the comments that we've received where we're incorpor—the feedback was very incorporated into both scenarios, added to it and sent it back out. It's ...

**Wes Rishel – Gartner, Inc.**

Thank you.

**M**

Wes, I just sent it to you, and I think you can—everyone can see it. There's inline comments in here from a couple of people. So, it was been helpful previously when either Cris and Scott have walked us through this document. Uh, should we continue to do the same thing here?

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

Yeah, right.

**MacKenzie Robertson – Office of the National Coordinator**

Joe, have you joined?

**Joe Heyman – Whittier IPA**

Yes. I'm here. I'm sorry.

**MacKenzie Robertson – Office of the National Coordinator**

Great.

**David Kates – NAVINET**

And Dave Kates joined. Sorry I'm late.

**MacKenzie Robertson – Office of the National Coordinator**

Thank you.

**M**

Terrific.

**M**

So, Cris or Scott, do you want to walk us through the test script, please?

**M**

Which one are we doing?

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

Outpatient.

**M**

Okay.

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

Cris, were you on the phone or no?

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

I don't think he is.

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

Okay. I'll give him a second. I'll get started with outpatient then.

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

Are you talking about Brancato?

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

Yes, I am.

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

I don't think so.

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

Okay. Give me one second.

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

So, Micky, for your purposes, we're—we're really just kind of starting at the very beginning and really talking—I think the first discussion will be around problem lists and reminder lists.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Okay, great. Thank you.

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

So, an outpatient document a lot of feedback, for example, is indicated in the purpose section. So, in the fourth, second paragraph I sent, you asked about way of example there is a lot of discussion around problem lists and the patient reminder lists. For example, I had a comment, you know, better definition of reminder lists requested from Joe Heyman reminder lists is not that prescriptive.

And the other comment from Joe Heyman was that physicians make, this is a report not a list. Um, first of all, Chris Brancato pulled out some information indicating that the list was consistent with the rule indicating the language that was used there which was why it was used in this scenario. So we just need to have some conversation and discussion about the exact reference of the—if more information needs to be added for patient reminder lists or people say like that—that usage is okay.

**Joe Heyman – Whittier IPA**

This is Joe. I don't think it's that important. ....

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

... Joe, you're okay with the word list as long as the understanding is that it has the characteristic of a report like you point out. Is that ...?

**Joe Heyman – Whittier IPA**

By, usually, I mean, that's what we do. We run, we pull our scenario to get these lists. So—

**M**

Yeah.

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

So, it sounds like we're, Joe, that we—and that we've ended up on the same page, right?

**Joe Heyman – Whittier IPA**

Right. I'm—I'm comfortable with it.

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

Okay. So, given that, Scott, can we move into the scenario it—oh, I think there was one other one on the advance directives.

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

It's not in that front section. However, there's comments later.

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

Yes, it's basically starting with the, under the certification criteria tested on page five.

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

Right. I didn't see anything between that comment and the one on page five, Cris. Did I miss something?

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

Great.

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

Okay.

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

No, I understand. I just wanted to make sure that we had an opportunity for people to make comments if they wanted to around the test because we have a couple people on the call who were not on the previous call.

**Wes Rishel – Gartner, Inc.**

This is Wes. I'm one of those. So, when I see comments on page—never mind, I'm on page five now. Okay.

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

So, I just wanted to—in the interest of just making sure we do it, let's just briefly note, does anyone have any comments or questions about the test methodology section on page three? And then, Scott, if you can keep walking us through. Sounds like not. Scott, could you just walk us through preconditions and then the rest of the document?

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

Not a problem. Um, so, in the precondition section, so we're it's never been typical as a provider side of care and the provider factors and the interactions throughout the sequence. Um, the list of certification criteria here was provided based on where we are currently. When we hit the—when we actually reach Stage 2, we'll update the criteria and that will be included there. They'll just kind of include it as an example just to kind of start the process.

So we have ... I'm not going to list them all, but essentially, the same form that will be used as we develop all the scenarios to incur what exact criteria are going to be tested there. We did have a comment on page five of the—at the very top of page five, looking at advance directives. The comments from Liz Johnson was that not every scenario will include the advance directives criteria and which we totally understand. The idea is to try to be as encompassing as we can with the scenario that's going to be, you know, cover as many scenarios as possible.

One other thing I wanted to reiterate to the group is that with the development of these scenarios, our goal was to ensure that certain pieces of these scenarios can be removed if need be if they're not going to be test—that—that particular product that is being tested with the scenario doesn't have that particular capability. Um, so, it's kind of building on a modular not to excuse the—the term between modular and complete product, but our modular kind of built out where certain parts of the scenario can be removed.

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

Right. And—and so, terrific, Scott. My comment was, for example, and I'm with you now, is that if we're doing the medication administration flow, the inclusion of a—the—the availability of advanced directive is not appropriate to that slide, but I follow you completely. So, I—what you're saying is with the final rules, the scenarios will be appropriate, but given the opportunity to have a vendor show a required functionality, it will be required because it's related to the clinical scenario or it will not be required whether it's connected to our, I know eventually we have to show it, but if we're doing the clinical scenario testing, and we'll just pick on advanced directives, advanced directives has nothing to do with medication administration, would you require it?

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

My thought would be no.

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

Okay.

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

You know, if not—if it's not really significant to that scenario, it's not—it's not going to be required, but I think in this particular one it was added you know, for completeness, but, you know, it can be parted from that .....

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

Right. So, I would—and I apologize because I was asking you more generic question, not necessarily to how—to outpatient is clearly attached to outpatient, but that was right. So, thank you for that clarification.

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

Um-hmm.

**Anne Castro – Blue Cross Blue Shield South Carolina – Chief Design Architect**

And Liz?

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

Yeah.

**Anne Castro – Blue Cross Blue Shield South Carolina – Chief Design Architect**

Liz, this is Anne. I joined late. I apologize.

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

Hey, Anne, not a problem.

**Wes Rishel – Gartner, Inc.**

This is Wes. Speaking as one of those who missed the last call, I'm a little bit confused by this table that starts on page four, scenario and workflow. Okay. Is the table that starts on page four a scenario? Is it a workflow? Is it a—a—uh, what is it?

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

Scott, do you want to respond to that?

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

Are you talking about the table on page four or the chart that comes on page five? Uh, the table on page four is just literally the list of criterion, a description of the URLs of the ... procedure.

**Wes Rishel – Gartner, Inc.**

So, they're the criterion associated with what, with the scenario or workflow, all—this all—are these all of the criteria associated with outpatient testing?

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

With this particular outpatient scenario, yes.

**Wes Rishel – Gartner, Inc.**

So, there are multiple outpatient scenarios since you said with this particular outpatient scenario?

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

Right. So, they—... I mean that there are certain pieces of this that can be removed or, you know, in—in a sense they can be added. Our goal with these was to develop them in such a way that if it was noted that, you know, if there was something that was missed, you know, this ... criterion could be added to cover those or something that was, you know, to essentially not fitting this particular scena—not for—not for these particular settings then it could be removed.

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

This is Cris. Look, wh—I'm sorry, Wes. I don't want to interrupt your—your train of conversation. I just wanted to make sure we got to the—the, you know, review of the purpose of this, which was, you know, the criteria here are the things that NIST will develop test cases for. The purpose for coming up with these scenarios was to improve those, the testability of those criteria by creating context, you know, clinical context for them. And the concern was that previously perhaps the clinical and workflow context was missing, which made the testing of the criteria not as good as they could have been. So, I think what we're trying to do is to make sure that we keep all these certification criteria in mind as we evaluate workflow scenarios. I just want to make sure that we return to that as kind of the purpose of what we're doing.

**Wes Rishel – Gartner, Inc.**

Yeah. Alright. So, just restating, the purpose is to make sure that the tests ... functions proceed in a clinically logical fashion, is that right?

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

Yeah, and that the criteria are not understood in a free-floating fashion but a grounded ....

**Wes Rishel – Gartner, Inc.**

I understood based on what went before.

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

Yeah.

**Wes Rishel – Gartner, Inc.**

Right. Okay. So, but this particular table does not represent a specific sequence of tests.

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

No.

**Wes Rishel – Gartner, Inc.**

This particular table represents all of the things that need to be tested in the various sequences of tests. Is that right?

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

Correct.

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

Yeah. It looks like, I mean, they're not ordered by section number. So perhaps that's confusing, right? We go to 302E to 314A-4 and then back to 302.

**Wes Rishel – Gartner, Inc.**

No, it's just I—I was—if this had been—depending on the answer to my question, it was either logical or illogical to have advanced directives in the table.

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

At the end.

**Wes Rishel – Gartner, Inc.**

Yeah.

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

At the end here.

**Wes Rishel – Gartner, Inc.**

I see now that it's logical because this—this table itself is not meant to state a specific sequence of tests that would be done.

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

No. It's not to be—not sequential at all, just for completeness.

**Wes Rishel – Gartner, Inc.**

Okay. So, it was mainly me playing catch-up ball at the expense of all the—all the hard workers who attended last time.

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

It's okay.

**M**

Helpful review.

**Wes Rishel – Gartner, Inc.**

Thank you.

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

So, then we go into ... of the scenario assumptions the next section, which begins to describe that and then a workflow that follows, just, you know, David wasn't here as well perhaps. I can't remember off the top of my head who wasn't also.

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

The other thing I was going to ask—I was going to ask on scenario assumptions is in here, under the active users of the systems, we included administrative, non-licensed and propo—professional licensed eligible providers, my only quandary, and I'm sure I'd figure it out when I got into it, but when I think of a professional licensed eligible provider, I probably only think of a physician, PA or a nurse practitioner, I'm sure there are others, not, for example, an office nurse. Is there nothing in here that would cover anybody but those persons because if so, then we've not covered all the actors. Do you follow what I'm saying, Scott?

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

Yeah I do. I think I think that that ... you know, especially the best we can.

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

Okay.

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

Um, I'm—I mean it's—

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

Thank you. May—maybe when we complete the scenario, we can come back and ask the question.

**Joe Heyman – Whittier IPA**

But I just suggest that you just take away the word non-licensed in front of clinical personnel because there are some that are licensed and some that aren't.

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

That was kind of, Joe, what I was getting at. Thank you.

**Joe Heyman – Whittier IPA**

The nurses are—are licensed and their nursing assistants may not be.

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

Right.

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

Okay.

**M**

Any other comments about active users?

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

Then, at that point, we'd have administrative personnel, clinical personnel, and then the—and then the EPs themselves.

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

Right.

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

Right. Perfect.

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

Okay. Okay. That's good enough.

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

So, a quick question, this scenario relates to adult patients. Um, obviously minor patients have specific workflow as well. Um that may just be a distraction, some of the um, minor patient issues, um—

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

But you know, Cris, you've got a good point. If we've got—there are specific pediatric requirements in meaningful use. So, either we need an addendum to this scenario for pediatrics to avoid writing a whole new scenario or a separate scenario. Uh, those would be two suggestions I might throw out to the group or to Scott and Carol and so on.

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

So, I guess that the question is—this is Cris. I think the question is, to—to Liz's point, is are those requirements of a pediatric visit, are the criteria specific enough that we need to develop a scenario in order to illuminate them, right? Again, the goal is to just use the scenarios to improve the testability, the criteria. So I can't imagine that everyone has encyclopedic awareness of what all those requirements are, but I'd be—it would be worthwhile to just ask briefly based on what people know about those criteria you know, do—do we think that a scenario is necessary to do it or can the criteria be testable o—on their own discretely.

**John Travis – Cerner Corp.**

The alternative—this is John Travis, might—

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

Hey, John.

**John Travis – Cerner Corp.**

Might be that there are particular data sets. Uh, you know, so if part of the test procedure is still to define a data set you know, cause I know we may have other criteria that have an age definition for the measure for the senior population. So, rather than going off and defining three scenarios for a senior you know and an adult of age 18 to 64 and one for pediatric, is it something that all of the—of the criteria make sense for inclusion but to allow for variance of testing, especially because for some measures it may matter, that you vary the data set to address the variance in patient age or similar circumstance where a demographic element distinguishes the patient population for a measure, and—and—

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

So, John, does that get interpreted and we don't do a separate scenario, we don't maybe even do an addendum but we just ensure that from a modular perspective that the pediatric measures are tested independent of the clinical scenarios?

**John Travis – Cerner Corp.**

Or adjunct to them as a requirement so that when you get to testing so that you're assuring that when you get to the measure, you've—

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

Right.

**John Travis – Cerner Corp.**

Accounted for that scenario. So, I think it's still a required part of it because we don't know the domain, you know, there's no telling that a, could rely on a vendor saying well, you know, or we don't sell to pediatric practitioners or to children's hospitals.

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

Right.

**John Travis – Cerner Corp.**

Well, there's honestly no guarantee of that. Um, so, someone out there could be basing use on it. So, just simply account for that in your scenario as when you get to immunizations or you get to advance directives, if the age criteria are a factor there, that you do in fact—

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

So, you know, yeah, advance directives ... pediatric population immunizations would.

**John Travis – Cerner Corp.**

Correct.

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

Yeah.

**John Travis – Cerner Corp.**

So, just account for it in the main flow, and I think the vendor would still test for both. You don't need to create another scenario for that. You need the test step to say, alright, now, you know, on this particular thing, assure you're addressing the test piece to account for that. I would think that would be possible without having to create a whole new scenario for pediatrics or for seniors.

**M**

Okay. Again, the only reason to create a scenario is to help identify where the relationship between criteria is unclear or those kinds of things. So, John, I'm hearing you say that this one, for the adult one, is—is sufficient enough to create a general frame?

**John Travis – Cerner Corp.**

Yeah, I think so.

**David Kates – NAVINET**

And then, this is David. I mean, maybe just a twist on what John just described, but rather than try and create separate scenarios, if there are age specific, gender specific, whatever, you know, some attributes that is noteworthy, just note it and just have a branch, if you will, on the test criteria that says, you know, special consideration for and what's that about, be it at the data level or the scenario level rather than create new criteria.

**John Travis – Cerner Corp.**

Yeah. I would agree with David's statement. I think that—that's exactly what I was trying to get after.

**M**

Okay. Should we move onto the workflow?

**M**

Any other questions?

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

I think we're good.

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

Okay. Alright. In the workflow, so this scenario assumes a clinical ... categorizes ... pages of pre-visit or visit and the post visit set of activities to represent the typical patient provider experience to interact with the certified EHR. Um, the next page, basically separates those spaces out in the previous sequence, the visit sequence and then the post-visit sequence.

**Joe Heyman – Whittier IPA**

So, this is Joe. I think calling them a sequence is what confused me.

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

Okay.

**Joe Heyman – Whittier IPA**

Because you have three arrows that go in a certain direction and then you call each of these three things a sequence, which means that, to me, that means that you start with access control, then you move to authentication, then you move to generating the patient level. And then, in the visit sequence, you start with access control, and you finish up with patient-specific education and .... And my—when I—what I tried to say was that it seems to me that your—the implication of this is that you need to do them in a certain order.

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

Okay.

**Joe Heyman – Whittier IPA**

So, I would either change the word—maybe I wouldn't use arrows. I would just use three sections with bullets, and I wouldn't call each one of them separately a sequence, although I clearly can see a sequence between pre-visit, visit and post visit.

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

Okay. I mean I'll—I'll take that back when—when we make—when we make the adjustments. I think the arrows just probably—I mean this is a ... representation to kind of show first, second, third, but I do kind of understand where you're saying if—if because I have that control come before authentication, that you will ideally do that first because the arrow does point down so that—that does depend there. So, we'll make some adjustments to that.

**Joe Heyman – Whittier IPA**

Thanks.

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

And then, the other thing in terms of the questions that were asked by Mickey and Cris on the view and download, which is really a lot about patient engagement, I understand we're not including Stage 2 yet, but I don't know—are we coming back to these scenarios after Stage 2 is public?

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

Yes.

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

Okay.

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

I mean, part of the reason why we wanted to those as best we could now was to get a good framework together. So, that when—when they to—when Stage 2 was out, we could just make the adjustments to the criterion as—as has been finalized in the rule.

**Wes Rishel – Gartner, Inc.**

So this is Wes. I think I'm echoing what Joe said in a comment. My comment's going to come across as picky, picky, picky, but the sequences in their scenarios, so you have a pre-visit sequence and a pre-visit scenario. What's the difference?

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

I'll just let ... and I'll adjust the language, so it's addressed pre-visit scenario for each one, and I think that because we used scenario throughout because it is a—this is a outpatient test scenario, the ... pre-visit scenario and visit scenario, I think the idea was to try to ....

**Wes Rishel – Gartner, Inc.**

Okay, great.

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

....

**Wes Rishel – Gartner, Inc.**

So, I was just redundantly repeating Joe. Good.

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

I appreciate it. Thank you.

**Joe Heyman – Whittier IPA**

Whenever Wes repeats me, I feel extraordinarily excited and brilliant.

**Wes Rishel – Gartner, Inc.**

Well, Joe, are you an obstetrician, Joe?

**Joe Heyman – Whittier IPA**

No.

**Wes Rishel – Gartner, Inc.**

I guess I can't have you treat me then.

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

It would be ....

**M**

That's an image. Let's move past that quickly.

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

I kind of wanted to let that linger to see if you have any additional comments, but I'll move on. So we'll make the adjustments to that, and we'll go into the pre-visit scenario. From the pre-visit scenario, the patient calls a provider seeking an appointment for ... medical condition ..., the patient's first visit to provider just indicating that there wasn't, you know, a visit beforehand. The administrator staff logs into the EHR, used their log-in credentials, and records the patient demographics into the EHR. After being away, the system does a automatic log off after a few minutes.

Several days later, in preparation for the patient's visit, the administrative staff uses the EHR again to produce a patient list for the provider, so the following day, which includes the visit of the new patient. Any questions there? Okay.

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

Okay, yeah, I think it's the next page where we start.

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

Okay. Right. Under visit, upon arrival, the patient provides additional information which before being seen by the provider through the sort of the general health questionnaire. Um, so the comment was do was that from Joe Heyman, all the history is how you take the ... patient from the patient directly in the—in the consultation room and the questionnaire in this case would not apply is that the typical case for most clinicians or—

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

Yeah, Joe, I was going to say when I read what your comment, my and my position here in Dallas is, I have electronic record, but we—he does collect the information in advance of seeing the patient. You don't have the patient fill out any kind of history and physical at all before they see you?

**Joe Heyman – Whittier IPA**

Nope.

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

I don't ask you know Micky, fro—Cris, Wes, I mean, I don't think that's—I think it's terrific, but I don't think it's a most common practice.

**Joe Heyman – Whittier IPA**

It may or may not be, and it—and frankly, if there's a requirement that there be a general health questionnaire, then in time, you can include it there. I'm just saying everybody doesn't do it.

**Wes Rishel – Gartner, Inc.**

Well, may I just would suggest we change the language to the physician may or the patient may, uh—

**Joe Heyman – Whittier IPA**

That's good with me.

**Wes Rishel – Gartner, Inc.**

Yeah. It,--yeah, we don't—I don't—we certainly don't want to imply anything about a—a requirement for practice based on the scenarios we create, but I think we need to recognize that it's just this common often in the workflow.

**Gary Wietecha – NextGen Healthcare**

This is Gary.

**M**

General but the questions that are listed here—eh—me—does this seem inclusive to you?

**Joe Heyman – Whittier IPA**

I—who were you directing that to?

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

I'm sorry. That was to you, Joe. This is Cris.

**Joe Heyman – Whittier IPA**

Oh.

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

Is—just—is—does the list make sense, I think?

**Joe Heyman – Whittier IPA**

Yeah, no, the list definitely makes sense.

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

Yeah. I think point taken that we ought to modify this to say that either prior to or in the exam the following information is gathered. Is that fair?

**Joe Heyman – Whittier IPA**

Well, yeah, I—I would just say that I think it just could—I think just using the word may would be enough.

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

Okay.

**Joe Heyman – Whittier IPA**

But I'm fine with either way. I—when I'm doing an exam, and maybe I'm the only one that does this, but I usually wash my hands and I don't handle a computer. I'm usually handling the patients. So this business of recording things in the exam room, I'm not quite sure how that gets done because in my office, I intentionally record everything in my consultation room. When I go into the examination room, I don't have a computer with me intentionally.

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

So, I don't see where—I'm sorry. I'm trying to follow you, Joe, and—

**Joe Heyman – Whittier IPA**

It—they—it become—it comes later.

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

Okay. Alright. So, we're not there yet. Okay.

**Joe Heyman – Whittier IPA**

Yes. It's down on—that's the fifth paragraph that—

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

Okay. So, cause one of the things I was going to point out one—once Cris, we're ready to get through this one, I have a question about on page seven, related to the description of who's going to do the information once you get to the patient room, and I don't. The only reason I think it matters if it's going to be demonstrated—so, the paragraph reads, the patient's called to be seen, they're identified through non-licensed personnel. They record vital signs, height, weight, blood pressure. The only way I think that plays into a test scenario is if it's in the product would obviously be tested to make sure it ... capacity or functionality is available to do those things.

My controversy with the—the paragraph itself is that, again, it may—it is—it may be licensed or non-licensed. Everybody, it goes both ways is all I'm trying to tell you. Everybody in an office doesn't use non-licensed personnel to record assessment data. Some use licensed. Some use non-licensed.

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

So, do we just need to say qualified there?

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

That's fine with me if it's okay with everybody else.

**M**

Yes.

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

So, qualified will cover it instead of saying licensed and like if we just say qualified indicates they, you know, whatever scenario, I mean, whatever, you know, sitting or ....

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

Right cause I don't—I don't know, 'cause you'll have to help me with the testing piece itself and John, you may know, or David or someone I don't know that you play into the testing the role-based perspective. In other words the—I think the requirement says you have to get this data in. I think as individual providers, we make the determination as to how the role's assigned that puts the data in.

**M**

Correct.

**Joe Heyman – Whittier IPA**

This is Joe. That—that entire paragraph is in the passive tense. The patient was called to be seen there.

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

Right.

**Joe Heyman – Whittier IPA**

It should be if she is identified, not they are because it's a patient, a single patient.

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

Right.

**Joe Heyman – Whittier IPA**

Um, but what I was going to suggest is just take out the by non-licensed personnel such as a health aide and just say they're—she or they are identified, evaluated and their measurements are recorded or they're taken, vital signs are recorded to include at minimum, height, weight and blood pressure. I don't think it's important to dis—to say who does it.

**John Travis – Cerner Corp.**

Yeah. This is John. The only times I recall that being significant is where it really, and for scenarios make sense, it's probably good, or for things like CPOE or electronic prescribing—

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

Exactly.

**John Travis – Cerner Corp.**

Where clearly, that can only be done by certain roles.

**Joe Heyman – Whittier IPA**

Right. So, I would just take out who does this.

**M**

Yeah.

**John Travis – Cerner Corp.**

Because this could be done by almost anybody in an office.

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

We—right. That—that's true because that eliminates using the question about do—do you need to show the case capacity and role-based entry because you're just saying can somebody put this stuff in.

**M**

Right.

**John Travis – Cerner Corp.**

Um, part of the testing for access control does ask you to show some examples of that, but they're kind of out of context of anything else and that still probably would be true of that unit-based testing that's in the script for access control but it really wasn't tested here other than where it mattered and that was implied in the—in the action. Like if we had to show co-signature, or if we had to show, you know, I don't think we did, but if we had to, you know, you might have to differentiate the midlevel provider from a physician.

**M**

I think we all agree that on the one hand, the system needs to demonstrate role-based access control. On the other hand, weaving it through the entire scenario is going to—is almost guaranteed to find some combination where there's a legitimate ... in a certain specialty that—that—that it'd be different than what we would get that for the overall scenario. So I'm with Joe that we don't identify who—what role does things except in the kind of situations that John describes where it functionally matters. Dead silence.

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

Yeah, I mean, I'm—I think we're there.

**M**

Yeah.

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

Scott, are we relatively clear?

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

I'm fine. I mean, it can't be, I mean, the indication from everybody is not necessarily just to take it out somehow somehow.

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

Yeah.

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

Don't be—don't be that specific and I get that.

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

Yeah, and Cris, are you okay?

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

Yeah. I mean it feels like this was intended to be a sort of a conversational scenario. It's nicely written. It's perfectly reasonable. I think the issue is how do you make it generic enough without being completely meaningless or have it become somehow, you know, very, very technical in some way.

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

Right.

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

Again, I think these are word—you know, I think that team has done a nice job of trying to thread that needle, but I think the feedback about making it as generic as possible is really helpful. I—I—it seems like a worth—worthwhile approach. I think we should try to step on the gas a little bit on the items at the bottom on page seven and on. There's—there's a number of detailed comments and I—we want to leave some time for inpatient as well. So—

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

Yeah, I, yeah.

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

So, we—should we move to the paragraph that says during the visit with the provider in which there's comments EM 9-13 on the next two paragraphs?

**M**

Yeah.

**M**

So Scott, do you—should we just maybe we could walk through each of these comments one by one?

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

Okay. So, starting on if we—so that we'll—we'll skip the during the visit with the provider cause I think we've gotten that reasonably clear. Um, starting on page eight, um—

**M**

Wait a minute.

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

Or do you want to go back to those?

**M**

Well on page seven, at the bottom—

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

Yeah.

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

That's all ....

**Joe Heyman – Whittier IPA**

.... Uh, first of all, a review of systems is not part of the physical exam. It's part of the history. So, I think that's a really serious mistake there.

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

Okay.

**M**

How would you edit that, Joe? Good catch.

**Joe Heyman – Whittier IPA**

Well, you know, it—it really probably belongs up at the top there where the—it's a general health questionnaire. I would assume that that also—those general health questionnaires usually have a review of systems in them.

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

So, Joe, how would you—how would you describe what we would call a head to toe because I think that's what Scott was trying to get to? So, you—you go in and you're examining the patient. You already have a review of their systems that was gender and history, but you're going to do a physical exam that also is head to toe, right?

**Joe Heyman – Whittier IPA**

Well, it depends on the circumstances and who the—and what the situation is and what the complaint is.

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

Sure, but could you say that might include a—and then what would you call that?

**Joe Heyman – Whittier IPA**

I would con—call—call that a physical examination.

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

Okay.

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

'Cause I think what we—what the indication was that it was a first time this patient had seen this physician. So, if they were doing this complete physical examination ....

**Joe Heyman – Whittier IPA**

... first time the patient sees the physician, the physician takes the complete review of systems, any problems with head, eyes, ears, nose, throat, pain or swelling or like lumps in your breasts, discharge from your nipples, pain in your chest, difficulty breathing, etc.

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

Right, but that—you—you do two things, don't you, Joe? Don't you take a verbal history, and then you do a physical examination that then confirms the history?

**Joe Heyman – Whittier IPA**

Yes. But you don't refer to that as the review of systems.

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

Right. That—that—

**Joe Heyman – Whittier IPA**

The review of systems is a distinct part of—of medical records—

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

Sure.

**Joe Heyman – Whittier IPA**

Set up in the history part.

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

So, what we would say then—I think what Joe is suggesting is we would say the provider then provide—performs a complete physical examination period.

**Joe Heyman – Whittier IPA**

Right. Or a pertinent physical examination because it, you know—

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

But you could say complete or pertinent and that would be your right. So, I think what Scott was trying to do was build a initial visit and what you're saying is that would cover an initial or one for a specific complaint.

**Joe Heyman – Whittier IPA**

Right. I mean, I'm assuming that somebody who goes to—I mean usually on a first visit, I frankly do a complete physical, but there are many gynecologists who on a first visit will just confine themselves to the systems that pertain to gynecology. So, they won't look in the eyes to look at their optic fundi.

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

Yeah. How they're written is good. Okay.

**M**

Alright.

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

Okay. So, I'll leave the—we'll probably add—we'll probably leave complete there, but we'll take the complete review of systems out to kind of make it a little bit more generic.

**Joe Heyman – Whittier IPA**

Right. And then, the next line says that information is collected and entered into the EHR during the examinations. I really have a problem with that. I mean, I know some people probably do that, but I wouldn't encourage it, and I would at least put a period after entered into the EHR.

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

Okay.

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

Can we—hey, Joe, could we compromise and—and do what you said which is or after the examination? I think the idea that was I'm just kind of putting words in your mouth so please correct me if I'm in wrong. I think the idea is to emphasize real time. So, I think the ....

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

I mean, it is—it is—is more real time and it's also just to indicate that it's the capability of that the system is available while the examination is happening.

**Joe Heyman – Whittier IPA**

All I can say is if I was being examined by a physician and in the middle of each portion of my body, they went over to a computer and typed something in—

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

Right.

**Joe Heyman – Whittier IPA**

I would expect them to wash their hands after every single click.

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

And—and so a different scenario might be that you do your review of systems and then wash your hands and then enter the data before, you know, while that's a ....

**Joe Heyman – Whittier IPA**

That's what I do.

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

That—right. And that ....

**Joe Heyman – Whittier IPA**

I finish the exam, and then, while the patient is getting dressed, I enter the information.

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

Correct.

**Joe Heyman – Whittier IPA**

Then enter the room.

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

Yes.

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

Okay. I'll keep—I'll notate that.

**M**

Okay. Should we go to the—

**Joe Heyman – Whittier IPA**

I would remove the word rule out.

**M**

Yeah.

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

Okay.

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

That works.

**M**

Okay.

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

Then, I guess we move onto the next page, correct?

**M**

Yeah. Any others before EM14?

**John Travis – Cerner Corp.**

I've been—this is John Travis, kind of looking for the place to make this comment, and it sets up a later comment I might make. The laboratory test to include et cetera which are sent electronically to the lab we're not testing any order of communication to the lab to my knowledge for Stage 2. I mean, we're testing, obviously, the placement of them, but I'm not sure we're testing the communication of them. So, I have a little reaction to the term electronically, you know, either we need to define it or we need to remove it because we're not testing any outbound communication of orders. Uh, we're not testing any—

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

That's true.

**John Travis – Cerner Corp.**

CPOELIS integrations, and we have a problem later with the clinical summary that if it's going to follow the function of Stage 1, it's going to have required content that includes lab results, and we never address getting lab results into the system and it's slow anywhere that I can find. So, really two suggestions, one is don't predicate the order of communications to be in electronic and that bullet, and number two, somewhere in here, I think we do need to work in how structured lab results get into the EHR prior to the clinical summary being generated because it is a requirement of the measure—

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

Yep.

**John Travis – Cerner Corp.**

That the clinical summary include lab results. So, that objective—that criteria for structured lab result incorporation should be tested somewhere in here prior to the clinical summary being produced.

**M**

That seems clear enough. Scott, can you—is it clear how to edit that section to take into account John's comment?

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

Yeah. I was just going to—just remove electronically.

**M**

Yep.

**John Travis – Cerner Corp.**

Yep, and then, address somewhere in this flow that there are some structured lab results need incorporated.

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

Yeah, that's a really good catch.

**John Travis – Cerner Corp.**

And—and in sequence prior to the clinical summary being produced.

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

Right.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

This is Micky. In terms of when we say clinical summary, and I'm sorry I'm not looking at the document, this is the clinical summary provided to the patient?

**John Travis – Cerner Corp.**

It is because I think, I'm looking ahead, yeah, the provider at—as the visit ends, I think it's farther another page or so, provide a user the EHR, provide educational resources, and then also ask the provider if they want an electronic copy of their visit summary electronically or on paper, the paper will ....

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

Yes. It's on page eight, guys, under post—is it post?

**John Travis – Cerner Corp.**

Yeah.

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

Yeah.

**John Travis – Cerner Corp.**

So, by then, you need lab results in the EHR to have been tested somewhere.

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

Yeah. And we, yeah, great catch.

**M**

So, John, left are handled in the last bullet point on the bottom on page seven. Is—can you just im—can we improve that?

**John Travis – Cerner Corp.**

Well, they're—they're ordered, yeah, I think we could incorporate somehow that, you know, maybe they're performed in office cause what's being ordered there is stuff, I think, I mean Joe would know better than me, but aren't those, um—

**Joe Heyman – Whittier IPA**

Well, they're usually sent out unless it's a very large physician system.

**John Travis – Cerner Corp.**

Okay. Maybe we want to revise the well, it depends on our goal here. Another alternative that I know is common is, you know, maybe the patient's instructed to come in during the pre-visit period to have that laboratory testing—the specimen drawn and so that the results might be communicated back by the time the visit occurs. I know that might add other things to the workflow, but that'd be one way to address it.

**M**

So, I guess there are a couple of scenario—one is that if whatever results are available for—and whatever has been ordered, right, and then there's a separate question of how results will come in afterward are then communicated ....

**John Travis – Cerner Corp.**

Yeah, which there is an aspect of that to show how pending results are identified. Um, I think that there's something in—in one of the criteria elements for the structured lab results, and well, probably more for the clinical summary that I know that it's kind of their scenario even in Stage 1, that producing summary, you need to be able to indicate what might may be pending as the lab tests or diagnostic tests. So, I guess the suggestion I'd make is because we do need the tests, lab—structured lab result incorporation, look to do it during or as a result of pre-visit specimen being drawn and those results being available by the time of the visit and then make sure that's part of what is addressed in the clinical summary that's given to the patient later on in the scenario and, you know, we already covered removing the word electronically, yeah, the—the bullet here.

**M**

Okay. Do we have enough feedback to edit?

**M**

I think so.

**M**

Okay. We move onto the paragraph at the top of eight.

**Joe Heyman – Whittier IPA**

So, there I just pointed out that flu and pneumonia vaccinations are not medications that go on a medication list.

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

So, Joe, is that true—uh, we do put them on our medication list, is that ....

**Joe Heyman – Whittier IPA**

We don't. We don't, and I don't have a—I mean, my EMR has accepted immunizations.

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

Okay.

**Joe Heyman – Whittier IPA**

And I—I think, you know, you're not going to find for flu and pneumonia vaccinations, you're not going to find drug/drug interactions. I just think they're very poor examples for using for a medication list. So, my suggestion would be to find two other drugs that are real drugs.

**M**

Do you have a suggestion?

**Joe Heyman – Whittier IPA**

Oh, I'm a gynecologist, so I—I'm afraid to make suggestions about—I—I mean, there are a whole bunch of diabetic drugs, insulin drugs, that could be there. Um, if the patient has something else, you know, which requires a blood thinner or something like that, those are the kinds of drugs that—

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

Well, could we—could we put a couple of categories and make it—of course, we do or they have to test for both.

**W**

Um, I hear you, um—

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

My question would be is if we just said to provide a selection of our medications from the system.

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

Right. And leave out—

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

Period.

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

....

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

And we don't—we don't include anything that—that—that ....

**M**

That's perfectly fine.

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

Is that okay?

**M**

Absolutely.

**Wes Rishel – Gartner, Inc.**

Question. This is Wes. Uh, are we in this point, attempting to be sufficiently specific to your drug/drug interactions downstream?

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

In this one, I don't think we're necessarily looking for drugs or interactions.

**Wes Rishel – Gartner, Inc.**

Okay.

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

To be specific here, like we're saying in the next paragraph, these are performed to drug/drug ... drug allergy interaction just so that they can do that but that will be really in the—in the medication management scenario versus ...

**Wes Rishel – Gartner, Inc.**

Long—ah—eh, you know, then I—my question is withdrawn or answered or something.

**John Travis – Cerner Corp.**

This is John Travis. Right into the—the last statement there, the contain on the patient's drug formularies provided by the patient's health plan, I've been waiting for three years to ask this question, this is a great opportunity. Um—

**M**

This better be great, John.

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

No kidding, really. The ....

**John Travis – Cerner Corp.**

We made a public comment how are you going to do that ... if you're not going to require the formulary plan benefit transaction to be used. How's that patient's health plan formulary going to ever be made accessible? They're not going to go build it as reference data.

You know, the system may come with a drug formulary, especially if they were—you know, I'm thinking more on the hospital side when we get to the discharge for ePrescribing, but how does that patient's health plan formulary come to be made accessible if you don't use the formulary plan benefit standard. We made a public comment at Cerner to ONC on the certification criteria of do you really mean to include that because you did so I guess it's a—that's the question I was waiting. How are you going to do this without the FNC standard? Maybe I'm ignorant or something as to how that can happen cause I don't even know how that's—you know, are you doing a phone call? Are you doing an online web access because it's nothing interactive the system's going to know if ....

**M**

Because, John, you've got something confused with your question, maybe it's just cause, uh—

**John Travis – Cerner Corp.**

Well, you know better than I, David. I—I'm not an expert on it. I just—

**David Kates – NAVINET**

No, no, no. I mean, you're—everything you've said is right. I just I'm not as familiar with having built it, you know, I'm grabbing formulary data from the ... I don't know if your comment is that there is—that—that industry standards don't exist or were treated in this formulary data.

**John Travis – Cerner Corp.**

No. The standard exists. I think we need to be—our comment was we need the standard to be tested here.

**M**

Okay. But that's what I thought you said. So—

**John Travis – Cerner Corp.**

No, and—and that's unresolved, and I know we can't predict what's in the final rule, but maybe there's a notation here to say this either remains described as is if perhaps ONC does determine to include the, you know, let's say the FNB 1.0 version, which would be the ... standard or it's taken out if they don't adopt it because—or you just simply leave it that, you know, ....

**M**

So, I can work with you and Cris and, you know, you know, if we just want to make a sort of friendly amendment type of thing to say—

**John Travis – Cerner Corp.**

Yeah.

**M**

The—what the expectation is in order to—to accomplish this.

**John Travis – Cerner Corp.**

Yep. Thank you. That would be fine. Well, it wasn't that dramatic, but ... for a long time because I've thought how—how are you going to do that? Otherwise, it's just narrative texts that really keep ...

**M**

Well, it's not as important to you.

**John Travis – Cerner Corp.**

Yeah.

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

Should we move to—I know where there's a fairly long comment from several people around educational resources specific patient specific educational resources, and Cris, let me just do a time check with you. Um, if we're going to have any time to discuss the 18-month discussion, we're either going to—and we have public comments in 15 minutes, how do we want to work that? Do we want to have a separate meeting or do we want—how do you want to—sorry, guys. We're going to have to try and do the logistics with the group together.

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

Yeah. Liz, my suggestion would be that—that both are time sensitive, but the commentary about the lead time on the rule is probably the most time sensitive.

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

Correct.

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

So, I would suggest that if we could try to move through this section in perhaps the next 15 minutes, reserve 10 minutes for discussion about the rule and 5 minutes for public comment, and then we'll need to set a separate time to deal with inpatient. How's that sound?

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

Right. Well, we have another meeting in like, oh, two—

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

Right.

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

A week or something that we could go over the inpatient.

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

Right.

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

Right.

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

Sorry. I meant that we could pick—use—exactly, use that time.

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

Yeah. So—so I think—so, sorry guys for the group workgroup as—as Cris and I were kind of talking together what we're talking about is getting through outpatient today and then as I introduced at the beginning of the call, we'd like to have input from this group about the concept of when the rules are coming out, it has to ... be put in play, and we could talk about that when we finish this. I think that's what Cris is saying. So, we could move through patient educational pieces and then ... then maybe we could get some ....

**M**

Let's hit the patient educational resources, comment EM15.

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

Right.

**Joe Heyman – Whittier IPA**

Well, I just—this is Joe. Uh, I— I would just like to be able to have a checkbox where you could check that you gave the patient an educational resource so that it's counted. What drives me crazy is—and I even hate the idea that I have to put in a checkbox, but in any event, there should be some way to indicate that you've given the patient something that didn't come from the EMR. And when you do give them something from the EMR, that should be counted too so that you don't have to count them.

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

Right. And—and does that—so—so that's one piece of it where you're saying just because the computer suggests a needed resource, I may add additional educational materials.

**Joe Heyman – Whittier IPA**

Or I may give something completely different from the computer's brilliant suggestion because sometimes the suggestion seems very irrelevant.

**John Travis – Cerner Corp.**

That's a good point. This is John Travis. We actually asked Rob Anthony about that cause a client of ours asked what if I ignore the suggestion the computer makes and I go choose something else, have I met the measure, and he did say yes.

**Joe Heyman – Whittier IPA**

Yeah, you do meet the measure, but there's no way to count it.

**John Travis – Cerner Corp.**

Yeah, distinct from other things unless it's just very generically recorded that education happened, yeah.

**Joe Heyman – Whittier IPA**

But still, you know, if you're a solo practitioner, you don't have personnel who can go through all your records and count up how many you gave educational resources.

**John Travis – Cerner Corp.**

I agree. I get your point.

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

Okay. Good, friendly amendments, shall we say?

**M**

Okay. John and Anne both had comments as well, and then, staff Carol and Cris. John or Anne, do you want to speak to your comments on this?

**Anne Castro – Blue Cross Blue Shield South Carolina – Chief Design Architect**

I'm reading mine. Hold on.

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

I think you went and actually looked up the text Anne, to suggest what they—what we were trying to address.

**M**

There she goes being efficient.

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

Yeah.

**Anne Castro – Blue Cross Blue Shield South Carolina – Chief Design Architect**

I'm trying to remember what I read.

**John Travis – Cerner Corp.**

Yeah. I think mine was largely covered by the kind of comment that Joe just made that the physician can provide other resources other than those that are suggested, and has that ability to test that particularly if the Infobutton standard is pertained, is going to be important to be able to demonstrate perhaps distinct from showing how the system can directly provide those resources. So, I think that's the point of the incorporation of the info button standard is it remains is to enable the provider to go out and say not only based on contextual suggestions from the system, based on things the system might know but also based on user input to say I want to go look for other resources.

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

Okay. And do we have enough input here to support editing?

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

I think so. We may have to revisit this again just kind—just to get a little bit more clarification, but I think we're fine as is right now.

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

Okay. EM16, I think as a grammar comment sounds good. Should we move to EM17 and items in post visit?

**Joe Heyman – Whittier IPA**

Um, well, I've said that already before.

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

Yep, yep. I think we're going to cover that up above, correct?

**Joe Heyman – Whittier IPA**

Correct.

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

... here. Alright, EM18 around reconciliation.

**Joe Heyman – Whittier IPA**

Yeah. I don't know how an EMR performs a reconciliation. Maybe this is just my naiveté, but it seems to me that a human being has to reconcile the two differences between a list that the patient presents and the list that's in the EMR.

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

Right. Sounds like we should have something that the system presents data to allow a med reconciliation.

**Joe Heyman – Whittier IPA**

Yeah. That sounds good.

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

Any other comments at the bottom of page eight or the as it goes onto page nine?

**M**

....

**M**

Just in terms of completeness, have we left anything out? Um, that's the hardest question for me to answer, what's missing, but are we missing anything from these scenarios?

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

The only thing I can't remember and it may be here is reminders—I know we talked about that at one—we talked about it, but did we ever test to see, I guess, in the scenario itself. I'm trying to remember that we would, that we'd send out reminders or have reminders or something.

**Joe Heyman – Whittier IPA**

Well, we've d—there's a thing—that thing about the reminder list at the beginning.

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

Right. ... Right, but I think, but help me if I'm—I may be—it really kind of talked about an example, but it didn't—when we got into the scenario itself, I don't recall seeing that functionality being tested. Did I miss it, Scott?

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

No. It's not. It wasn't specifically called out here.

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

So, we may want to add that to the scenario.

**John Travis – Cerner Corp.**

There's one other—this is John. I, well, I think we addressed it. I'm trying to recall how in my fog of the patient list, but I'm pretty sure it was in there, wasn't it?

**Joe Heyman – Whittier IPA**

Patient list.

**John Travis – Cerner Corp.**

Yeah. Trying to look back real quick to see if I can pick up where we put it.

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

Yeah. The reference was a paper reminders criterion 170-304 D.

**M**

Is that what you mean John, the patient reminder list—

**John Travis – Cerner Corp.**

No. I mean for the—

**M**

Or you mean the list of patients.

**John Travis – Cerner Corp.**

The list of patients.

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

Right.

**John Travis – Cerner Corp.**

I don't know that there's—why that wouldn't be able to be something you could test in here as maybe, you know, there's some contrivance of the patient having been identified to be on a list based on their—on a combination of the factors that are required for the list to be generated because the list could be for a variety of purposes. Just wondering if that could be included in a sensible place the ... judge of that of what the sensible place would be.

**M**

And in this context, that would be to identify that a patient is on a list for some purpose like population management or—

**John Travis – Cerner Corp.**

Yeah.

**M**

Follow-up care.

**John Travis – Cerner Corp.**

Yeah.

**M**

So, presumably, that would be something that could live next—near where it says generate patient list. I think it also is generate list of patients or determine if that patient is on that list for purposes of ....

**M**

On page eight—

**M**

Yeah.

**M**

It says the staff uses the EHR to electronically generate a list of patients that require follow-up care.

**M**

There you go.

**M**

There you go. I—thank you. I—I was thinking it was in there. I just wasn't—

**M**

Nicely done.

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

... clarify more ....

**John Travis – Cerner Corp.**

Now, I assume that is that specific it is to generate some lists ....

**Joe Heyman – Whittier IPA**

It says that the list is generated based data on the EHR and sorted based on the providers' preferences. The data could derive from the problem list, active medication list, medication allergy list.

**John Travis – Cerner Corp.**

That's good.

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

Okay.

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

.... Anything else that we're missing, improvements?

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

Great job.

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

If not, why don't we swap to the, this discussion about the timeline for the rule? Um, Liz you keyed this up at the beginning of the meeting, and I also think we should probably say for disclosure purposes, there's been some discussion between Liz and I and the two chairs of the Standard Committee, John Perlin, John Halamka and um a very valued member of the Standards Committee, Arien Malec about how to approach this and potentially to draft a comment to address this specifically.

**Arien Malec – RelayHealth – Vice President, Product Management**

By the way, Cris, I wanted to note that I'm on.

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

Oh, good. Is that you, Ken?

**Arien Malec – RelayHealth – Vice President, Product Management**

That's Arien.

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

Arien. Oh, good. I—Arien, I sent a note, a ... e-mail that Ken Tarkoff, because he wanted to be included.

**Arien Malec – RelayHealth – Vice President, Product Management**

Yep.

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

Will you make sure he knows we're having this discussion?

**Arien Malec – RelayHealth – Vice President, Product Management**

Yeah. I think Andrea's already let him know.

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

Great. Thank you. So—

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

Arien, given that you're here thank you. I mean, you've drafted a note to—to ..., to Marilyn Tavener as to CMS and Jeffrey Zentz at OMB to, you know, address this issue. I think we should just let you speak to this and look for feedback from this team. Is that fair, Liz? Does that seem like a—

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

Yes, absolutely. And—and Arien, the one thing that's not in the letter that I brought up to—I don't know if you were able to hear or not was we—the 18-month rule that we—and it—that we've talked about repeatedly and twice had made the recommendation.

**Arien Malec – RelayHealth – Vice President, Product Management**

Yeah. It actually is ...

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

Is it there?

**M**

....

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

Thank you.

**Arien Malec – RelayHealth – Vice President, Product Management**

Yeah. I could—I could make it more so. So I've as Cris noted, I've been emailing with the—with the chairs of the—this workgroup as well as the Standards Committee with my concern around where we are with the regulatory timeframe and between the five of us agreed on a set of talking points, and so the letter that I wrote really just puts those talking points into—into letter format. Uh, essentially, what it says is it reiterates the 18-month timeframe from the publication of the NPRM to start a meaningful use period. It notes that there are a large set of activities that need to take place in order for hospitals, in particular, because they're at the tightest risk given the October 1<sup>st</sup> start date need to—to s—um, to go through an order, to support meaningful use that includes development of technology quality assurance of the technology, where that quality assurance needs to take place against the final meaningful use measures and certification criteria in .... That is typically, you're not going to release your final 'cause there was a cost to release your final product. You're not going to release your final product against just the NPRM 'cause you have a significant risk of failure. Um, then, you need to get that EHR technology tested and certified with an ONC accrediting testing lab and an ONC accredited certification body against the final test scripts.

You need to upgrade the EHR technology in the hospital. You need to train physicians and staff on the upgraded technology. You need to test the upgraded technology in your workflow. Uh, you need to enter—eh—implement interoperability workflow. And then, finally, you need to move everything to production and move physicians and staff to use the upgraded EHR and upgraded workflow interoperability and all of that needs to take place before October 1<sup>st</sup>.

So, I reiterated that timeframe and then noted that we're in the first part of the process based on the based on the draft measure and certification criteria in the NPRMs. So to get to the meat of the ask the ask is to expedite for CMS, ONC and OMB to expedite publication of the final rules in the federal register and then, ONC expedites development and simultaneous publication of the associated test scripts. Uh, Ken noted when we discussed this that the term expedite is subject to interpretation, and we may want to consider I did say something about each additional week of continued delay in publication and rules places the ability ... to achieve Stage 2 Meaningful Use at risk. You may want to put some guardrails around ex—what expedite means. Uh, because the last paragraph says should expedite a publication of rules, not we possibly further recommend a start date for Stage 2 be moved in order to release the risk of hospitals who are not able to meet the timeline. So, that's the—that's the essence of the letters currently drafted.

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

Well, Arien, and in workgroup the one other—and—and I haven't had a chance to talk with—with Cris and Arien and the Johns about this, but the other option that we might put on the table and so this is, you know, cold. In other words, we'll just react to this, is I don't—cause of the mandate, because of the, you know, the law that we're dealing with, another option could be that rather than move the date in—in its entirety, in other words, the 365-day period starting October 1, 2013, what we could ask for is that they would go back to the 90-day period versus 365.

**Arien Malec – RelayHealth – Vice President, Product Management**

Yeah. That—that would also .... also work.

**M**

I mean, obviously, the sticking point here for CMS and OMB is that the effective dates of the rule are keyed to the beginning of the federal fiscal year—

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

Right.

**M**

And the calendar year.

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

Right.

**M**

And those are not arbitrary.

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

Right.

**M**

So, for us to ask OMB to move something off the cycle of federal fiscal or calendar year, you know, may cause enough challenges that that, that what you just proposed may be a more practical approach.

**M**

Right. Right.

**M**

Given the ... reality.

**Arien Malec – RelayHealth – Vice President, Product Management**

If I can repeat that back, what I'm hearing is the start date is the same, but the effective dates or the updated—and I think that's—I think that's in—what I intended to say.

**M**

Yeah.

**Arien Malec – RelayHealth – Vice President, Product Management**

The start date for the meaningful use period is the same, but the effective dates for the update for the use of—of Edition 2014 certified EHR—EHR technology and meaningful use measures is made more flexible.

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

Well, what I was thinking—so, I think you might have been saying this, Arien—

**Arien Malec – RelayHealth – Vice President, Product Management**

Yep.

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

But, you know, I want to be sure we're on the same page, what I was saying, when we started Stage 1, year one of Stage 1 requirements said you must have 90 continuous days—

**Arien Malec – RelayHealth – Vice President, Product Management**

Right.

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

Of blah, blah, blah. And what I'm suggesting is if that we could buy ourselves enough time to actually get code written and go through all the stages you've described very well, if we then had to show compliance with those measures for 90 days, not 365. If we don't get any relief there, then—and I, you know, we've all said, the feds are kind of stuck with the October 1 start date, and we all know why, but if we said during that federal fiscal year '13, the, as the persons who are testing would only have to show 90 continuous days of compliance, then we could buy the best of both worlds, I think.

**Arien Malec – RelayHealth – Vice President, Product Management**

I think that makes ... because ....

**M**

Makes sense.

**M**

....

**John Travis – Cerner Corp.**

I think you meant federal fiscal year '14.

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

I'm sorry. I did, John. Thank you.

**M**

Um, can it, John, I'm sorry.

**John Travis – Cerner Corp.**

I was just going to point out one—one last thing. I think it—it's a very, very good proposal speaking as somebody who's likely to bear a significant burden over the next couple years working on the certification part of this or—for—for us. But one complication that remains, and it's the fact that during 2014 all use is predicated on the certi—certified EHR technology being certified against the 2014 criteria set. If you have a Stage 1 user still during 2014, unless there's provision made for them, they're stuck.

**Arien Malec – RelayHealth – Vice President, Product Management**

Actually that's—sorry. This is Arien. That's not true because the way that the—the new criteria are written, you can achieve Stage 1 Meaningful Use with edition 2014 certified EHR technology.

**John Travis – Cerner Corp.**

No, no, I know that.

**Arien Malec – RelayHealth – Vice President, Product Management**

Yeah.

**John Travis – Cerner Corp.**

But you're going to have to be on a full-year reporting period was where I was going with that.

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

But—but, John, for ... so I'm going to give a real lofty example at ..., I've got 26 hospitals that are going to have to do Stage 2, while I have 14 hospitals doing Stage 1 at the same time.

**John Travis – Cerner Corp.**

Right.

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

And what we're—right now, as currently proposed, what we are facing is 365 days for both because—and I actually have 14 more that will be in the first time. So, let's just talk about Stage 1 year two, Stage 2, year one.

**John Travis – Cerner Corp.**

Exactly. Stage 1, year two, now I—now I'm still, you know, presuming that if you're Stage 1, year one in 2014 and some still could be, they have a 90-day period, so I'm not worried about them. I'm worried about the people who are past their 90-day period for Stage 1, and they're in year two or, you know, well, presumably, they're in their year two—

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

Right.

**John Travis – Cerner Corp.**

2014, they're facing a full-year reporting period and as things stand today, they would have to have 2014 certified software to use as of October 1, 2013. That's the group. I've said that to Steve Posnack half a dozen times in the last year and a half, and I think—

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

Wow.

**M**

Thank you.

**John Travis – Cerner Corp.**

... but they are still stuck.

**M**

Thank you.

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

That's a very good point.

**M**

So, I will write that into the letter as well.

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

Yeah. that's an excellent point, John.

**John Travis – Cerner Corp.**

Now, I don't—now, I think that's a policy dilemma because you've already given one reduced reporting period for Stage 1 to those folks and now, I, you know, I can—

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

....

**John Travis – Cerner Corp.**

Challenge the policy remedy saying you get a second one.

**M**

....

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

I well, wait a minute though, John. I don't think that's true because if you reported in federal fiscal year el—whatever, the first year.

**John Travis – Cerner Corp.**

Twenty—let's—let's make it very concrete.

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

Eleven.

**John Travis – Cerner Corp.**

Those not at 90-day period in 2013 if they're—if that was their first year of use, now they're in year two of Stage 1, that is a full year in 2014, they will ha—as things stand today, they would have to have a 2014 certified version of software as of October 1, 2013 to support that full year of use.

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

Yeah. See, those persons that you're talking about, John, that are in their second year, are not the same people that got the extension because those persons were already certified. They are today—today, this calendar today, they're in a 365-day period—

**John Travis – Cerner Corp.**

Right.

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

For Stage 1. So, it is only those who, I would be included, who are doing Stage 1 now would begin Stage 2 October 1, or we're going to 14 now.

**John Travis – Cerner Corp.**

I'm not worried about people who are in Stage 2 use in 2014. I'm worried—

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

Gotcha.

**John Travis – Cerner Corp.**

About people who are facing a full year—see, here's the kicker, whether it's one client or two hundred—

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

Right.

**John Travis – Cerner Corp.**

Every vendor's going to have to get certified by October 1 of 24—2013.

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

13, right.

**John Travis – Cerner Corp.**

To support Stage 1 users who face a full year.

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

Right.

**John Travis – Cerner Corp.**

... fiscal year 2014. So, all the relief we might get for Stage 2, year one, does us no good because we still face a requirement to get our stuff certified to support those full year Stage 1 users in federal fiscal year 2014.

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

So, Arien, we do need to capture that because—

**Arien Malec – RelayHealth – Vice President, Product Management**

Yeah. ....

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

That—that—that is a real—that—you're right. So, we need to solve both problems.

**Arien Malec – RelayHealth – Vice President, Product Management**

And—and—and just to reflect back what I think the solution or the ask is, is to support a model where I may start fiscal year 2014 with—with edition 2011 certified software and if I'm only qualifying for Stage 1, I may be able to stay on that Edition 2011 certified software the whole year.

**M**

Or upgrade at my convenience.

**M**

Or upgrade at your convenience.

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

Right, but that's ....

**M**

That would solve it, yes.

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

Yeah. And then, for Stage 2, those persons would be given a 90-day attestation period and—in lieu of a 365-day attestation period.

**Arien Malec – RelayHealth – Vice President, Product Management**

At which period—at which—in order to qualify, they would absolutely have to upgrade to—

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

Correct.

**M**

2014 certified software.

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

Sorry, Cris, to monopolize. I'm sure there's others that have points. I just wanted to make sure that we ended up on the same page.

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

No. This is a fantastic conversation, exactly what we wanted. I think—I wanted to make sure that we had awareness of the Implementation Workgroup and support for the idea of sending this letter to the regulatory authorities here, um—

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

Yeah. So, I would say, Wes and Micky and Joe and Anne and David, we haven't heard from.

**Anne Castro – Blue Cross Blue Shield South Carolina – Chief Design Architect**

I'm good. It's Anne.

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

Okay.

**Joe Heyman – Whittier IPA**

This is Joe. What little I can understand of it, I'm good.

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

Joe, I—I—I can assure you as another provider, you want this.

**M**

Well, that's exactly—

**Joe Heyman – Whittier IPA**

Thank you.

**M**

... let's—let's—let's put a point on that. I mean, I think it's helpful for the fact that our vendor representatives here Arien and John and you know, Ken Tarkoff and others are speaking up to this, but this is not just a problem for the vendors. This is a problem for the hospitals and providers.

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

Right. I would tell you Cris, from the hospital provider perspective we would be fully in favor of this.

**M**

Well, since I'm about to change hats, I'm in favor of it too.

**Ken Tarkoff – RelayHealth – VP & General Manager**

.... Hey, Cris—hey, Cris, this is Ken. Sorry as I was on earlier.

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

Hey, Ken.

**Ken Tarkoff – RelayHealth – VP & General Manager**

Hey. I—I would—I would support that point, and I would even argue that this is more of a provider issue than a vendor issue.

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

Yes. I—and—I—

**M**

Exactly. Thank you. Thank you.

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

Yeah, Ken, I would a—uh, Ken, this is Liz. I would agree with you.

**M**

Alright. So, it sounds like we have full vocal support for this. So, are there any comments to improve the message before we move onto public comment? And I think we should take a few minutes to just talk about what we want to do in our next meeting, just housekeeping.

**Arien Malec – RelayHealth – Vice President, Product Management**

So, just in terms of—of next steps for me, I will make the—the suggestions that we talked about. I will make those edits. I will send it to the Implementation Workgroup as well as to the Standards Committee chairs and then assuming that we get agreement there, it'll be at the chairs' discretion for sending it on.

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

Right.

**M**

So, Arien, you're going to distribute to everyone on this workgroup—

**Arien Malec – RelayHealth – Vice President, Product Management**

Correct.

**M**

Is that correct?

**Arien Malec – RelayHealth – Vice President, Product Management**

Yes. That's right.

**M**

Thank you.

**M**

Alright, Liz, should we just talk about what we want to do in the—in the next meeting—

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

Yeah.

**M**

When we make a bash at it. I think we did a good job with outpatient.

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

Yep.

**M**

Uh, we had previously covered medication management, and so, I think our work that remains is inpatient.

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

Right. And then, I think—and Scott, I wanted to ask—I don't know if Carol ever joined us—are we also anticipating we will get an ED scenario?

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

Yes. That ... scenario ....

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

Yes. I agree. Yes, right. So, I would say, Cris, that the next I think we meet on the second or something like that, the next agenda will be focus on the inpatient.

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

Right. And will we have a draft of the ED by that time, so we can give it a—I mean, it's been helpful to do kind of a first read. Um, Scott, is it—is possible that we would have that available by our next meeting?

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

Yeah. I can have that sent out before then.

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

That'd be great. So uh it feels like if we were to spend the majority of our time on inpatient and just spend maybe 15 minutes in the next meeting, kind of doing a preliminary walkthrough of the ED scenario, I think that'd be really helpful cause then we'd get informed comments that we can dive into in a subsequent meeting.

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

....

**M**

That would work.

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

Works for me.

**M**

Fantastic. Alright, should we just go to public comment?

**MacKenzie Robertson – Office of the National Coordinator**

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

**Operator**

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

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

Wow. Great work. I think all around.

**M**

Nicely done, everyone.

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

Very well.

**M**

I think everybody gets four minutes back. How 'bout that, Liz?

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

Wow. That's .... I'm telling you. We are better than one could expect. So happy weekend all, and we'll talk to you in le—about a week.

**M**

Thank you, guys. Have a good day.

**M**

Bye, everybody.

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

Bye-bye.

## **Public Comment Received During the Meeting**

1. Is there no transcription today?
2. Outpatient Visit: There is no Review of Systems for this initial visit. The Review of Systems is part of the Initial Visit with a (new) Patient.
3. Before Diagnostic Testing is ordered, the Physician needs to make an Assessment. The Assessment includes the formulation of a set of problems, and each problem has a plan (which may include orders).
4. The Review of Systems is taken BEFORE the Physical Examination. The Review of Systems is part of the History.
5. It would be good to have the patient log into a Patient Portal, to view their Laboratory
6. Thompson Boyd: It would be good to have the patient log into a Patient Portal, to view their Laboratory Results in 48 hours after the initial visit.
7. Influenza and Pneumococcal Vaccinations should be part of the database, along with routine Tetanus immunizations. These immunizations are not part of the Medication List. However, the vaccines should be entered in the CPOE system, so a patient with an egg allergy would show up, using the clinical decision support rules.