

**HIT Standards Committee
Implementation Workgroup
Transcript
January 28, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee's Implementation Workgroup. This is a public call and there is public comment built into the agenda. The call is also being recorded, so please make sure you identify yourself when speaking. I'll now go through the roll call. Liz Johnson?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Liz. Cris Ross?

Christopher Ross – Mayo Clinic – Chief Information Officer

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Cris. Anne Castro?

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Anne. John Derr? Timothy Gutshall? Joe Heyman? David Kates? Tim Morris? Stephen Palmer? Sudha Puvvadi? Wes Rishell? Ken Tarkoff? John Travis?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks John. Micky Tripathi? Gary Wietecha?

Gary Wietecha, MD – NextGen Healthcare

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Gary. Rob Anthony? Kevin Brady? Tim Cromwell? And Nancy Orvis? And are there any staff members on the line?

Scott Purnell-Saunders – Office of the National Coordinator

Scott Purnell-Saunders.

MacKenzie Robertson – Office of the National Coordinator

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

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. Well I think – good morning, everyone, and Cris is driving and joining concurrently, so he will be in and out of the call, but mostly with us. So, the plan for this morning is that we review what Scott has planned to release on Wednesday as far as a first clinical scenario and provide him any last minute input into the – I would say Scott, maybe the understandability of it, so that people can follow it and give us good feedback. Is that a fair assumption?

Scott Purnell-Saunders – Office of the National Coordinator

Yes it is.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. Great. And so, I think that is the plan for this morning and before we go to the actual document, I'd like to ask Cris if he has any other comments.

Christopher Ross – Mayo Clinic – Chief Information Officer

I do not. Let's go through the document. Thank you.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

All right. So with that, Scott, we will turn it over to you.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. Good morning everyone. I emailed the document to the workgroup last week, so you could start to walk through it, because it still is in draft format, I didn't want to display it on the call, since it's all being recorded. I mean, it's not quite yet available for public comment, but we can certainly talk through it. So, if anyone needs me to email that to them again, just let me know and I can forward that to them quickly.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And when you say it's not quite ready, is – have the dates changed, Scott, or...?

Scott Purnell-Saunders – Office of the National Coordinator

No, no, no. It's still, we're still planning to release it for public comment Wednesday. The issue is, we still – we would to incorporate whatever feedback we've gotten on it before then, so that we can send it out to folks on time.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. Great.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

So Scott, is there a slide deck to project?

Scott Purnell-Saunders – Office of the National Coordinator

No. The slide deck that we talked through last week was updated to add a little bit more of the intermediate steps, but it's essentially the same deck that we talked through. But we want to try, I guess, to have a conversation about the updated work.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I'm sorry; I'm struggling with finding it real quick here. I know you sent it, I saw it. There it is.

MacKenzie Robertson – Office of the National Coordinator

So Scott, the slide deck from Friday is the one to project up.

Scott Purnell-Saunders – Office of the National Coordinator

No. That was the slide deck that was sent, the slide deck that was sent before wasn't the one to project, it was, you can just project ...

MacKenzie Robertson – Office of the National Coordinator

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. So, concerning the document, I do apologize, it is 66 pages and if we begin with the first page, I'm going to essentially recognize that the format for the test scenario procedure is exactly the same as the regular format for the test scenario document. Just give me a second, all right, you were quick.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I have not looked at this, I will admit to that Scott. Did we get to a place, because in the presentation, we were all struggling with the use of words and what was a test script and all that kind of stuff? Is that explained in here? I mean are you going to attach to this...I don't know what the regular sort of methodology is for putting this out into the public for feedback. I mean, I know this is a normal protocol that you follow or template you follow, but remember, when you were trying to explain to us what you were doing, you were using...we were very confused by the various words, because it didn't seem to be consistent to us. Does none of that go with this?

Scott Purnell-Saunders – Office of the National Coordinator

So, the – along with that document would be, we're going to actually post part of the updated scenario presentation that we submitted, that we updated late last week. So, the expansion of the test scenario versus the test script and kind of how they parallel and how the various individual unit tests are going to be linked together. So, there will be a description document that will go along with this. We had a presentation to the test labs and the ONC certification bodies late last week with the updated deck and got a little bit better feedback than the first deck that we sent, with the workgroup last week. So we will be adding part of that included with that, too.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And when will we see that. Because I think, certainly people like John in particular can certainly add, and I have folks on my team that can certainly give you feedback on this particular test script, but I think where we may be of the greatest help to you is to be able to give you feedback on that part of it, I mean, that's what we were all kind of – we were all struggling.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. So I can certainly send out a ... this morning.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Go ahead, Cris.

Christopher Ross – Mayo Clinic – Chief Information Officer

Yeah, Liz, this is Cris. Yeah, that was my primary issue that I wanted to get to. I don't have the deck because I'm driving, but I read through it pretty closely. Agreed we can provide comment on the details, but I feel like definitions and a glossary up front is really important because this is complicated stuff. I also think we need to be pretty ruthless about walking through it and making sure that there's only one name for everything. There's a glossary in our previous decks, and I think in this one a little bit, we're using, I think, different words to mean the same thing.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So how do we – are you still planning on releasing it on Wednesday Scott?

Scott Purnell-Saunders – Office of the National Coordinator

Yes, we are.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. So how do we help you, I'm not, you know, we want to be of value in this process, and I'm not sure how to help you without that sort of ... unless you can take us in this test script to where that actually exists and we just missed it, those who read it.

Scott Purnell-Saunders – Office of the National Coordinator

That actually – so no. The version of the test script that was sent doesn't include that, that explanation, a dictionary and document. So, let me backtrack. It might be better if I forward back out the updated slide deck, and maybe we can talk through that.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yes. I would agree with that. Cris, is that okay with you?

Christopher Ross – Mayo Clinic – Chief Information Officer

Yup, I agree.

Scott Purnell-Saunders – Office of the National Coordinator

So MacKenzie, I'll send you a PDF of the slide deck now and you can actually project that on the screen and we can talk through it.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And then, I think everybody's been with us through that process except John Travis, you weren't here last time.

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

I joined late, I think.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay, so you do know what we're talking about. I just didn't want you to come in ... because as one of our vendor partners, I think you're probably more qualified than some of us to tell us whether it's feasible, what we struggle with, you heard last time, was just trying to keep the words straight.

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

Yeah.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And while Scott's – we're getting that up, can you tell us from the perspective of a testing participant, is what we talked about last time, I mean, was it logical to you and would it save you time or ... and make this process more effective or not?

Christopher Ross – Mayo Clinic – Chief Information Officer

John?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

John that was a question for you.

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

Oh, I'm sorry, I just didn't know. I apologize, please repeat it, I didn't think the question was ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

That's all right. When we were going through the slide deck last time and we were very concerned there was – we were confused by it, and we also wanted to be assured that what we were putting out there was actually going to make the testing process better. And I couldn't tell, I mean, I couldn't tell ...

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

Yeah, I had a hard time. I took a look through more of the details and, I'm not trying to...it got a little hard to decipher and, it seemed like a stitching together of the detailed test procedures, which maybe is exactly what it is. And, I didn't take a real hard look at it, but it was, I think, highly leveraging the test procedure content that had been out there before. So, as far as efficiency, the efficiency to be gained would be reduction in the test data that you'd have to go necessarily deal with that in unit testing you'd be essentially having to build out.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah, that was the same impression I got. I mean, it didn't feel like new tests and Scott it may...

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

No, it didn't. And honestly, that's probably where I kind of stopped was in looking at a few of them, I'm going, I think I've seen this before. And I don't know that a detailed review of that would be, would yield much of a difference. The ... taking a different eye and it would take some more time to see if that's necessary or not, it would be, did we really reduce redundant setup. And probably so, I would presume that, and some efficiency of setup. But the details and test steps look very familiar.

Christopher Ross – Mayo Clinic – Chief Information Officer

Yeah, this is Cris. Just to – that's really helpful to know John. I think just this context and Liz or Scott or MacKenzie, correct me if I'm wrong, but I think the whole purpose of having scenarios is two-fold. One was that efficiency issue and then the second was clinical realism and accuracy and effectiveness. Whereas we were having things that were tested in Stage 1 that were disjointed or there were simple data flaws that aren't addressed by scenarios or addressed elsewhere, but I think we want to hold it up to that double standard of both efficiency and then also efficacy of testability. Is that everybody else's recollection?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

That is certainly mine.

David Kates – NaviNet – Senior Vice President, Clinical Strategy

Liz and Cris, it's Dave, I finally jumped on.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Hey Dave.

Christopher Ross – Mayo Clinic – Chief Information Officer

Hey David.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President – Tenet Healthcare Corporation

Yeah, that's – so now we've all lighted on kind of the same page. I think we're struggling because what we thought we were going to do was, like you said, get clinical relevance so that we wouldn't hear from our testers and/or the people that were looking at the testing scripts, that this makes no sense in a clinical scenario. You're asking us to do things that – both the testers were being asked to do things they wouldn't really want to build into the functionality of their hardware, software, excuse me, and an end-user wouldn't use it this way, so, we're trying to fix that. The second thing was, is to eliminate redundancy, I mean, I think you're absolutely right ...

Christopher Ross – Mayo Clinic – Chief Information Officer

(Indiscernible)

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

... and that's where I was – I think all of us are struggling Scott, so you're going to have to help, because it doesn't feel like we're there. But maybe we're just not understanding what you've done.

Scott Purnell-Saunders – Office of the National Coordinator

Okay, that makes sense. I sent the updated document to MacKenzie, hopefully ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

It's up on screen.

Scott Purnell-Saunders – Office of the National Coordinator

Great. So, let's start talking through it – just give me a second.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So Cris, what's up on the screen is the PowerPoint from last Monday, but with revisions, I believe.

Scott Purnell-Saunders – Office of the National Coordinator

Yes. So, let's go to the next slide. Next slide. So, you know, I just talked about the purpose was making clinically relevant interoperability piece and interoperability certainly for the reduction in setup and repeat setup for all the various testing.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

But see Scott, your slide here doesn't say anything about the concept that we ... and it may just be an oversight, there's nothing here about the concept of reducing the repetitiveness of retesting something, you know, a data element several different times for the very same thing.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And like, like was kind of alluded to, we're not sure that got accomplished, but we'll keep going.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. Next slide. I mean, I think once we get to start talking through the individual scenario we mentioned last week, it'll be a little more clear.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

Next slide. So here's our terminology document, where we're basically going to explain the ... piece of information that we'll continue to talk through, not only in this presentation, but also in the test scenario procedure itself. So the narrative test case scenarios are what we're referring to as the test scenarios that we developed last spring and early fall, so those will be narratives that were done to basically explain and reflect the clinical workflows that we talked through, and those were the things we got feedback on to be able to be refined and improved, based on the feedback from the workgroup.

The test scenario is the broad term used to describe the "linking" of unit tests. So that's an overall principle, so when we're referring to test scenarios in general, that's trying to combine the various unit tests in a clinically relevant workflow. The test scenario diagram is what we've been talking through, just showing individual test procedures and the linking with the data in the boxes that we'll go through in detail later. The test scenario procedure are the actual "linking" of the unit tests in the procedure, which is the document that was sent to you guys late last week, explaining how the various individual test scenarios will be linked with the unit testing test data. And then finally the test scenario data is the data that can be used during the testing with the test scenario procedure, to ensure there's consistency throughout. So that tests the "inter" in interoperability and ensures that you don't have to have a repeat setup and breakdown for each individual test.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So, is this the complete list, because last time I think there were others, or maybe not. This doesn't seem

...

Scott Purnell-Saunders – Office of the National Coordinator

This is it, so ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay, we're going to be going through the deck and we'll be able to tell.

Scott Purnell-Saunders – Office of the National Coordinator

Right, we're going to continue to try to use, stay consistent with this use of terminologies to ensure that it makes sense.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So why don't we pause for a second. Everybody clear or relatively clear on the words themselves, the terms being used?

Christopher Ross – Mayo Clinic – Chief Information Officer

So this is Cris, I don't see the deck, but I hear the words unit test and test procedure, are those the same thing?

Scott Purnell-Saunders – Office of the National Coordinator

No. The unit tests are what the...the unit tests are included in the test procedures. So each test procedure basically has one unit test that is used to provide ... or support or testing for that particular procedure.

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

This is John. I'll offer the comment, because I just looked through to make sure I was seeing what I thought I was seeing. But, what was in what Scott sent out last Thursday I think is, in fact, the exact test procedures that were published for what would be certification criterion, like criterion test procedures that were finalized back in mid-December. But the test data has yet to be put together.

Scott Purnell-Saunders – Office of the National Coordinator

Right. So we're working on including the test data in that scenario procedure for posting this week.

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

So, I wouldn't do any additional detailed review of the test procedures, because we've already seen them.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

M

So what ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So the question would be, though, if that's the case, what are we accomplishing? I'm lost.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. So our goal with this was to one, make sure the proof of concept with this idea worked ... certainly we had some discussion and some problems with this approach last week, as far as the use of terminology and consistency. And the goal in sending out the actual test scenario procedure was to get just a first take on if it makes sense. Certainly the data is a large part of this, and kind of connecting use of individual unit tests ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I'm sorry, Scott. I'm going to interrupt you, just – and I apologize for interrupting you, but I didn't make my question clear. What I'm asking is not what you've accomplished; I'm asking the more global question. If we're using the same test procedures and we're just linking them together, how are we getting efficiencies, removing redundancy, and making them more clinically relevant?

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy

Scott, this is Judy. I've been lurking, Judy Murphy on the line here. Let me take a stab at this. I think what the difference is that we're taking the unit test proced – excuse me, the test procedures that are linked to the unit test and stringing them together and what's different specifically is that we're using the data from the first test in the second test, getting an output and using that data in the third test. So, it is now requiring the test data to move between the unit tests, rather than using different test data for every one of the unit tests. Am I being clear now? I'm not sure.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

That makes sense Judy. Would it be then – then the secondary piece of that then is the clinical data or clinical test data is derived then it would be test data that's more relevant to the testing scenario being performed.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy
Right. And it's logical because it's created around a workflow and the – again, the data from one is put into the other, rather than thinking about them all in isolation. I don't know Scott if you want to more like fast-forward to the diagram that kind of shows this, I'm not even sure if that's in the slide deck, but I know I've seen that ...

Scott Purnell-Saunders – Office of the National Coordinator
It is.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy
... diagram.

Scott Purnell-Saunders – Office of the National Coordinator
It is ... forward the slide deck and I can stop you guys when we get to it.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy
And one of the – before we go there, I see us using an acronym on this particular slide that has not been defined, TDP, I don't even know what that is.

Scott Purnell-Saunders – Office of the National Coordinator
That actually was a typo; it should be TSP for test scenario procedure.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy
Then I'm not going nuts, okay, thanks.

Scott Purnell-Saunders – Office of the National Coordinator
You're not. That TDP should be TSP.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy
Okay. Thanks.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
Yes, TSD.

Scott Purnell-Saunders – Office of the National Coordinator
So I continue forward and basically on ...

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy
I think the diagrams help us, by the way, is my only point. So we might want to think about actually, I don't know, pulling it up, but it doesn't fit before terminology, I don't think. But right away, these questions come up, you know.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
Well that's kind of Judy what we were proposing earlier, and I don't know when you had a chance to join us, and thanks for being here. We were saying as we began to look at the test procedure, if you haven't seen that diagram, I think it might be ver – this is where I'm not familiar with your rules and templates and procedures, so that you and Scott know this, can introduce something like that in or not. I don't know what the rules are.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy
So Scott, keep going and then maybe let's have this conversation again at the end and say, if you weren't you and you were Joe Schmoie, and you were using this slide deck to understand what we were talking about, would it help.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President
Yes.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. So continue forward to the next slide please. So this is basically exactly what we talked about before, what was done and what was, what was done before and what was completed currently. So you can just go to the next slide on this. This shows the unit test and the test scenario data that we've also been discussing. Next slide.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Hey Scott, there's that word down there below, did we – go back to the previous slide please that I do ... scenario narrative was not in your list of things to be explained.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. I could actually ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I'm just trying to tie them. Keep going.

Scott Purnell-Saunders – Office of the National Coordinator

Got it. The scenario data was ... the scenario narrative was the kind of the human readable format and words that would go inside the procedure. So it would actually add some of the clinical explanation and relevance as to why the tests are linked together, to kind of provide a little bit of that background. In the actual test scenarios...excuse me, the test procedures that were developed before, there actually is a narrative piece that goes into some of them that sort of explains what test is to be done, so it's not just on a standard list of steps that have to be followed. Thanks a lot. So we can actually skip through these, these are exactly the same as they were, so the next four slides, are going to explain how we went from the standard narrative test case scenario from before.

Next slide. This shows all the five pieces that were actually built into the ones that we're working on now, as far as the EHR interoperability intake, that's the one that we're going to talk to in detail. The patient intake, the patient integration, ordering and med management and then the patient output, and that actually reflects the combination of the scenarios that were developed last year, as far as the overarching setting descriptions and the ones that we're working on now. Continue forward, next slide. Here's the work showing how the data out of each of those is extracted and that basically reflects back to what Judy was explaining about how the unit tests are connected. Next slide.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Hang on a second. Okay. When you say extracted, I understood Judy to say, rather than extracting it from these tests...oh, I see. It's the same data you extracted it from previous testing, is that what you're saying?

Scott Purnell-Saunders – Office of the National Coordinator

That's correct. So the unit test, for example, med list, med allergy, problem list, clinical info rec, will have the same data that will be used in each one of these smaller pieces. So for example, the data that's used in EHR interoperability intake, that is used to reflect the tests between the five that are listed there, would then be used and then continued in the patient intake and then continued in the patient integration. So the idea is to produce smaller versions of a testing scenario that can then be used as a building block to build the larger ones that are developed. So one of the designs from the diagram that we talked through last week, and we'll actually continue forward and I'll be able to show you guys the test data that's used in the EHR interoperability intake scenario, where we showed the 1, 2, 3, 4 steps last week, that same data would then be passed through, building into the ordering and med management piece, as we build up a larger test scenario procedure.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Hey, this is Anne. I have a question that will help me as we go through this. What does this PowerPoint have to do with the 66 pages?

Scott Purnell-Saunders – Office of the National Coordinator

This PowerPoint actually explains how we got to the 66 pages and trying to combine the individual unit tests that are listed directly together in that procedure itself. So ...

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

So, if I spend time understanding this PowerPoint, and I think it's much better than it was. I don't see any of these terms or this context in the 66 pages.

Scott Purnell-Saunders – Office of the National Coordinator

So, what you'll see in the 66 pages, for example, are the connections between the med list, the med allergy list, the problems list and the clinical info reconciliation as well. So it's linking those five test procedures that were developed and posted in December 2012, with how they would – those could be written into an actual testing procedure that could be given to a test lab for testing directly.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

So, I don't see the context obviously. Maybe our vendor folk on the call can address that. It just seems like this makes sense to me Scott, the PowerPoint, but when I look at the test procedures, I don't see any of the same terms, I don't see the context. I see a lot of descriptive individual development of test information. I'm just – so I want to alert the team on the call to let me know if that's an issue, because you know, I have ... my challenge is the clinical connection.

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

This is John Travis again. I, you know, I think the proof is going to be in the pudding of the test data set. I will tell you again, looking at the test procedures, they look like again, stitching together of the unit test procedures from ... that were finalized in mid-December as they are, without any change.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Right.

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

And so right now, without knowing how the test data set might consolidate or collapse down, what would otherwise be unit test, unit test, unit test, unit test, as if we were to go through certification the way we traditionally have, I can't tell you where the efficiencies are going to be gained. I think that the test data's going to make all the difference to that assessment. So for example, looking at this slide, I would not expect to have to go create data for the clinical summary in redundancy to anything that I could obtain as a result of going through the test scenarios. If I do those ... if I do the unit tests in isolation, I would go enter a med list, I'd go enter a med allergy list, I'd go enter a problem list. There would be no guarantee that that data would be reused for the clinical summary, and indeed, they have their own test data sets. But in a scenario, I would expect the med list I put in during the intake scenario and the med allergy list and problem list would directly be used in the summary without me specifying it. So that's the kind of thing that I can't tell ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right.

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

... the test data set's going to make the difference.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

That's what Judy described to us ...

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

Yeah.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

If indeed what Judy described is what happens, then I think the process does become not only more streamlined, but also more effective from the perspective of this would actually happen in a clinical setting.

Scott Purnell-Saunders – Office of the National Coordinator

So the test data – not to interrupt – but the test data that we’re working on shows the ... shows how those tests will be linked together and shows what data elements will be present and how they’re consistent throughout the various tests that are listed. So, currently, and I’m...let’s continue on in the slide deck. The next few slides are going to basically show ... keep going please. Next slide. So that shows the old design and then where the scenario based testing came from. Next slide. Next one, I want to actually show the beginning of the diagram. So here is basically what is present and the test scenario procedure direct document that you guys saw last week. One, it’s a linking, it shows these individual test scenario ... test ... as a listing of the test procedures and unit tests that are present here. So where you see the 1, 2, 3, 4a and 4b and then the testing criterion that are currently listed. Next slide.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Hang on just a second before you go past this, because we’re moving fast. You’re saying here – the only thing, in looking at this from before, I don’t remember looking at it, now I don’t necessarily understand 4a or b, are you talking like – oh, I see. This is the setting, the actual setting for care.

Scott Purnell-Saunders – Office of the National Coordinator

That’s correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. And so then we – or you’re saying you would have – so why would you add the data there, why wouldn’t you have a test set for an EP, a test set for an EH, why would that not be the approach? Or if you want to do it by setting, do hospital, ambulatory and I don’t have to go through the settings, you’re as familiar with them as I am.

Scott Purnell-Saunders – Office of the National Coordinator

Right. The idea with this is to try to build smaller versions of the test scenarios that would, that could actually be built quickly and tested against, so we’re looking to just build entire sets on what exactly one would look like for an EP or exactly one would look like for an EH may be a bit challenging at the beginning, so ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right. So we don’t test by scenario...I mean, we don’t certify by location, right, we test by EH, EP, CA, whatever, right?

Scott Purnell-Saunders – Office of the National Coordinator

Right.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So if we’re testing now by setting, what’s the link? Because when you get certified, you certify into – John, do you certify overall or do you certify by EH, EA, you know, EP, whatever?

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

Compliance

You certify by EP and hospital distinctly, they’re different events ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So anyway, just a sense of why would you then certify the setting, which is where the test scenario leads you to, right.

Scott Purnell-Saunders – Office of the National Coordinator

Well these are just – these happen to show what the tests are listed under, so where they would be relevant to re: setting, whether it be inpatient or ambulatory. So, it’s not that this particular, this one scenario would just be for an EP or this one scenario would just be for an EH. This shows how those tests individually would link back to those settings. Does that make sense?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

It doesn’t to me, but if everybody else gets it, maybe I’m just not as ...

Scott Purnell-Saunders – Office of the National Coordinator

So for example, some procedures directly are only valid for inpatient and some are only valid for ambulatory.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So, and I guess the way we've used this, not because it's pure, but because just to make for simplicity in previous calls, we've sort of equated EP with ambulatory and inpatient with EH, not that that's also...

Scott Purnell-Saunders – Office of the National Coordinator

That's correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. So that ties a little bit. I don't know about everybody else on the call, I don't want to belabor it if everybody else is understanding it.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

So does that mean its optional if you're actually an EP certifying, or the tool is ambulatory and not inpatient, it's optional to execute both, A and B?

Scott Purnell-Saunders – Office of the National Coordinator

Yes.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

So you just go down the path that's relevant to your certification request.

Scott Purnell-Saunders – Office of the National Coordinator

That's correct, just as you would today, if your particular product doesn't meet, or is designed to meet your inpatient settings, it wouldn't have to test the ambulatory design ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

As long as the certification bodies and the vendors are clear that based on this type of a layout, that's what you intend.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Right. So, you're doing one-size fits all in the diagrams, but you follow a path depending on what you're certifying.

Scott Purnell-Saunders – Office of the National Coordinator

That's correct and that's the idea – it's following the same principle of the unit test design. So if your product only fits or was a model designed to meet three or four of these steps, it would then fit ... four as necessary to meet that particular certification.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. Next.

Scott Purnell-Saunders – Office of the National Coordinator

Next slide please. So this then shows how those data pieces are going to be added to connect the various unit tests together. So you see step 5, step 6, step 7a and 7b, those are the data that would be connected to tie them in together there.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So that's where, again, I think it's semantics, but what was understandable and made sense from a just usability perspective was when Judy said we have a single set of data that's taken throughout and here you're saying you add data. And maybe it's just that you take from a global set of data and use it at different places in the – it's not that you're adding, it's that you're accessing appropriate to the piece that you're testing. Is that true or not true, because ...

Scott Purnell-Saunders – Office of the National Coordinator

That is true. I mean, I think we're mixing terms here ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

That's what I think, it may be semantics.

Scott Purnell-Saunders – Office of the National Coordinator

... add ... the data ... essentially the data that's used here is the data that's best designed to connect these unit tests together. So, as we've been explaining and discussing, we wouldn't have to reset up a test or clinical info rec or a med allergy list or a med list, as we'll show. You would use the same set of information to pass through all of those.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy

Yeah Scott if I might again, I think – for example Liz, maybe this helps. When you go from 1 to 2, the data is passed between 1 and 2, and that's what that little triangle with 5 is meant to say.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy

However, your point is well taken that in order to execute test 2; your guess is that you also have to add other data.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy

And so to make this complete, and I don't know if we're want to actually add this to the diagram, there would be additional data, and I'm picturing an arrow coming in from the bottom, into number 2 ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Exactly.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy

... which would ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

From the original data set ...

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy

... well ... or, well no, the original data set to me is what's represented with 5.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

And maybe building test data is a better term than just test data set that uses data already stored in the EHR, because that implies it's just pulling forward, when in fact you're adding to it...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

... bringing in ...

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy

Yes, it's a combination, that's exactly right. If the med list, for example, would move from 1 to 2, but under number 2, you're probably adding in smoking status.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Or something, right.

Christopher Ross – Mayo Clinic – Chief Information Officer

So this is Cris. So I guess the question that I've got is the reuse of this data means teeing up a data set to use over and over and over in a whole bunch of tests is not a particularly difficult issue. I believed it was the case that we were trying to modify the test data as it moved through the – both the test procedures and then the broader scenario, so that we were testing the right thing. It isn't actually the creation of data that's the hard point; it's about getting it to the right state, so it's teed up in the right way for the next testing event. Do I have that right or was that never the intent or am I not asking the question clearly enough?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I understand the question. Scott or Judy.

Scott Purnell-Saunders – Office of the National Coordinator

Um, I think you're – so, let me backtrack. The idea of building the test data set and modifying the current set that's there to fit one particular pass through the test is actually still correct. So the idea is the data set that we're currently building for this draft test scenario procedure will reflect a clinically relevant workflow. The idea, once that data set's built, and is tested and designed, it will then allow those tests to kind of show – when out of one test can then be essentially passed into the next test, with other additional data, and continue testing forward in a clinical sequence that makes sense. So, to answer your question, yes, that's the goal, it's not to design a specific data set that is only unique to this scenario, but to design one that makes sense for not only this one, but others as well, using the existing data that we've had, that exists in the current unit tests that were published basically late last December.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

You know, I'm almost tempted to put a bubble on top of this whole slide that explains in English ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

... what you're saying versus what you've put on the slide.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

That's kind of – we're sort of in the same place. We're not trying to create work for those who don't need it, just because we're struggling through it, maybe the testers, the certifying bodies and the – John, the vendors, this would not be confusing to them. But I think we're looking for assurance that it's useable, and I know that's what you all's goal was, and that it's, we're accomplishing our goal. And I'm like Judy, if it's – I don't know what the sort of protocol is, but if this is coming out new to me and I were looking for something that explained to me what we were trying to accomplish with this new approach. Because if I were trying to make a choice when I went in for certification, and I had heard about or knew about or was just looking for alternatives, I would want to understand what benefit was this to me as a person coming in for certification. I did streamline the process and did it – I mean, they may or may not be as interested as we are in the clinical relevance, but I think they are.

Christopher Ross – Mayo Clinic – Chief Information Officer

Well, and I think it's going to be relevant, but I don't want to go out on another path here. I guess to me, the think that has always been helpful organizing principal in my head has been, if the base thing that you have to pass is unit test, and frankly I'm still having a hard time distinguishing what a unit test is and what a test procedure is, but maybe that's just me. But ... if there's a description that you have to pass these tests and that that's the certification gold standard, that doesn't go away. It's the same in Stage 1, but what we've done here is to try to, again, weave these together into larger assemblies so that it's both more clinically relevant and so that the testing approach could be more efficient. And then describe how we've accreted on top of that sort of core unit tests and core data. That's the only way I make sense of this, but maybe that's ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah, I agree with that.

Christopher Ross – Mayo Clinic – Chief Information Officer

... maybe, yeah. So I think we should have a description up front about what did we do in Stage 1, what are we trying to do different in Stage 2 and therefore what have we built here and what does it mean, and then go into the diagrams for the detail.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And I, I'm going to pile on a little bit with Cris and Anne both is that I think Scott, you obviously have mastered this, and it's very, very clear to you. But, as we come in on a weekly basis and try to add, I think we're scratching our heads trying to make sure we're there and part of it is, just having it in very simple words that explain just what Cris outlined.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. We'll work on simplifying this so it makes a little bit better sense.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

I mean, I'm just really trying to think, not just for us, because that – at the end of the day, of the folks on the phone, only a couple of – well, actually, I guess I'm involved in certification, too, it's more about how you know, this is a big step forward for ONC in the testing arena. And we want for the work to be recognized and understood that this is really listening to what has been a consistent request from the public, from the certifiers, from the ... so on. So I'm just – I want you to be able to, and Judy and others, Farzad, to be able to take what all this work and really show that you've listened and you did what was said and by looking through this deck, I can't tell that.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So, let's go on to the next slide please.

Scott Purnell-Saunders – Office of the National Coordinator

So this shows the "linking" of the unit tests with the data that was added, showing how you'd actually, for the first set, you basically combine test 1 and test 2 with the data and process in test 5, or the one beneath it, you combine 1, 2, 3, data from 5 and 6 and so on, just showing how that actually would work.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

And this doesn't indicate any repetiti, repeating the same test again, is that – it's just simply saying that by going through this step, you meet all of those?

Scott Purnell-Saunders – Office of the National Coordinator

That's correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

And I'll detail that as we move forward, once we get into a little bit clearer diagrams from the individual tests.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

Next slide. So this just breaks out what those individual boxes looks like, and Cris, this ties back to the unit test that we were talking about, which shows individual test procedures that are listed. So for example, med list is in box number 1a, med allergy list is in 1b, problem list is 1c and the TOC is in 1d. Those are actually showing the individual test procedures that were designed and listed directly separately in the flex unit based testing, as currently exists in testing, what we did for Stage 1 and what we're trying to improve on for Stage 2 with the scenario document. Next slide.

This shows the addition of the clinical info reconciliation, which actually reflects what the scenario will be, taking all the other test procedures that were designed, so med list, med allergy, problem list and then TOC, and then how they actually are going to be combined in the clinical info reconciliation, for the scenario to happen. Continue forward. So now you'll see with the data and the information being passed from box 1a into box 2 and from box 1 b into box 2, so you'll see the combination of the medication list coming down from the med list test into the clinical info reconciliation, being combined with the C-CDA from box 1d and combining to show the med list in the C-CDA format. I'll pause here. This same design will essentially reflect what the scenario will decide...will actually prove and show, and this will actually continue from each one of these boxes in succession.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So, if we – from a clinician’s perspective, I would have flipped these boxes. Because in my thinking, I would have gotten the C-CDA in, I would have created – first, that would be the first, you know, the patient’s here, they come with a C-CDA. I have a med list that I’ve created or have in my ... either via assessment I’ve created or ... my EHR I have an allergy list. A problem list doesn’t really get generated, except for historical, until you’re here. So, then those kind of things all get combined and put into reconciliation, I guess. And using reconciliation here I think is being used differently than I do it in my head, which is actually going through and doing a reconciliation, the meds that you brought in, the meds that you’re going to take in the hospital, you know, the meds that we’re going to add so you get to a singular list. Here, I’m – it’s almost like a consolidation rather than reconciliation, I think. Does any of that make sense to you Scott? And I also don’t know what CIR is.

Scott Purnell-Saunders – Office of the National Coordinator

That’s Clinical Info Reconciliation.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

So, I mean, I understand that but for our design here, we’re trying to show how each one of these individual procedures and unit tests will combine to reflect data being passed into the clinical info reconciliation. So, if your workflow is different and every...from a clinical standpoint, if it’s kind of reversed, we can try to redesign and kind of change the diagram to reflect that, but we still want to maintain and show that each one of these tests is validated and is done correctly inside the scenario. Continue forward with the slides. This will just show how the data was passed and we don’t necessarily have to talk about it in detail. I mean, now you’ll see the clinical...the reconciled med list goes back up to the med list test. And the same thing continues for the next 3 or 4 slides, showing how the data is being passed from individual tests down to the box of test 2. Does that make sense from a clinical standpoint or are you still with your workflow...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Well, I understand what you’re doing. I don’t know that it – you know, what you’re trying to do is ensure the functionality is existent and that we’re able to capture the data as appropriate to reconcile and then send it back for utilization in the clinical scenario. I get that. I mean, it sort of depends on what the point is, if the point is intake, which is I think what you said we were testing, then I think the point of intake includes the C-CDA, based on our – the fact that we’re trying to promote that concept, and then the data that’s collected either in the immediate hospital assessment or EP assessment, and/or what’s historically already available in the EHRs. I don’t know if it matters, maybe it doesn’t matter. I’m again, trying to make it relevant and I wouldn’t start – I mean, it’s like you’re doing this med list, but you’re not taking advantage of the C-CDA as part of sort of your starting point. I don’t know if we have another person that understands on the phone, kind of what you do when you actually ...

Christopher Ross – Mayo Clinic – Chief Information Officer

I – yeah, Liz, I agree completely. I think our HIE hearing tomorrow – the point of this, we didn’t put the C-CDA further up. I think that’s a debatable issue, a fine point, but I think it’s important ...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Right, and I’m not saying that everybody comes with a C-CDA and I get all that. But if we’re trying to promote that as our future of interoperability, then we should be promoting it in these scenarios.

Christopher Ross – Mayo Clinic – Chief Information Officer

Absolutely.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

We'll take that into consideration. Next slide. So basically just shows how information is passed forward. Skip about two ahead for me. Keep going. And one more. All right. So that's the entire picture and how the data is being passed back and forth. Any of those tests, like I said, could be done in any order, just to reflect a typical workflow, so we'll certainly adjust it so that the C-CDA plays a higher role in it, and we'll work on that and get an updated version out to the group. Next slide.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Hey Scott, when you say they're tested in any order, again, that confuses me when we use the word that we're doing something that's clinically relevant. I guess what you're saying is you might do the med list first, you might do the allergy list first; at the end of the day, you've got to do all three, allergies, meds and problems, to get to the end result. Is that the only point you're trying to make there?

Scott Purnell-Saunders – Office of the National Coordinator

That is correct. So there's not a prescribed order that's necessitated by the scenario, so whatever...if in your practice you do the med list first and someone else does an allergy list first, that can happen in the prescribed order you prefer.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

So this actually shows, this slide shows the sets that were done in the previous five or six slides, in combination with building into a larger test scenario procedure. So it kind of covers up the other pieces that are there, and in the next slide you'll see that the data that comes out of this particular small scenario would then be built into the larger one. So, you'll see in the lower right hand corner, as denoted by the red trapezoidal shape, those tests that are there and then how the data's passed across into an overall medication management and ordering scenario.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So are you going to show us a slide that's going to show us what this testing scenario is going to contain, because this is a subset of data, a subset of testing, unit testing, it's going to lead to an intake scenario that you're going to present, correct?

Scott Purnell-Saunders – Office of the National Coordinator

Correct. So this was the ... this is the larger medication management one that we described and talked through earlier this year, as a narrative only. This would be what that would actually look like as a fully developed test scenario procedure with all the linked scenarios that were – excuse me, the procedures that were published and the updated data to link all the various tests together.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So, in English, so something that's going to make this for my head. In my world, if I were going to test ordering and medication management, I would do 1a through 7.

Scott Purnell-Saunders – Office of the National Coordinator

That's correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

All right. And again, I think we need to figure out with you kind of the more logical, if it's supposed to be intake, where intake actually starts, but we can help with that. You want to go to the next one.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. Yup.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Next slide please.

Judy Murphy RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs and Policy

So while we're going to the next slide, this is Judy. I just want ... one more thing. I'm having this "ah-ha" moment here that maybe a way of presenting this is to first talk about the narrative workflow in a diagrammatic form. And what I mean by that is, forget what we have test procedures for, forget unit testing versus string testing or integration testing, whatever the heck you want to call this, and instead, consider that we have a workflow and we define that workflow using a traditional workflow diagram. And then we take and overlay this test procedure stuff on top of that traditional workflow. Maybe that's a way of up front explaining what we're trying to do.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

That's a great idea Judy. And I think it would also keep everyone clear on what would be a normal progression of steps.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Let me observe – this is Anne – that maybe everybody's workflow is not in the same order, and that maybe just a narrative that describes that the test scenario reflects just a scenario, not all of them, to remove some of that angst.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah, I think that works. I think, for example, like said, you may not have a C-CDA available to you at the time of intake, and you may be going ... and you may not have any historical data, so you may be simply taking a med list, a problem, creating a problem list and creating an allergy list. I mean, you may be starting from step one, but for testing purposes, I think that we want to show ideal, right, to ensure that the functionality is there, if you have all. Does that make sense, Anne?

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Yes.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay.

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

And saying that is the end result of what, 25 minutes of discussion? You know, maybe if we just said that to begin with, we could have avoided the 25 minutes of discussion. And that's the point, what can we put in there to help people get past it.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Exactly. Yup. And I like – Judy, I like the concept that we would lay a workflow that most of us, certifiers, vendors and providers of all types, would understand and then if you overlay this scenario based testing on top of it, then I think what Anne just said starts to click. And if you will attempt that Scott, and get it out to us, just that piece, then we can help you say yes, John, from your perspective and Anne, from your perspective and me and Cris and Dave and others, we can give you immediate feedback just on that simple part of it. Because us trying to delve into, you know, is this the right unit test, is beyond my comfort level.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

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

Well and again, this is John, I think those have been reviewed and vetted pretty seriously, so, there's not much value in that. I think the test data set is very important and the one constraint to apply is, no matter how you do arrange the testing steps, don't lose sight of the dependency. So they could be collected in any order, but don't introduce a step that presumes it's been recorded if it hasn't been, so...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Yeah, for consolidation purposes, good point. And you're right. The other thing we can help with, whenever you need us Scott, is to look at the test data itself, because that's where we kind of hit some bumps in Stage 1, where we had clinical data or clinical procedures or whatever, in the test data, that were no longer in use in the real world, and we want to help with that, to avoid that for you.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

So, we are quickly running out of time. I think we need to go to public comment. And I apologize to – we'll come back in just a moment. If there's anyone else who wants to add last minute, but I don't want to miss the obligation to get to public comment.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

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

Caitlin Collins – Altarum Institute

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

Operator

We have a comment from Carol Bickford. Please proceed with your comment.

Carol Bickford – American Nurses Association

Ah, this is Carol Bickford from the American Nurses Association. I wanted to identify that there was a problem with connecting to view the slide presentation. The only access we had was to the agenda, so, it was a technical difficulty; it was disconcerting.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Thank you, Carol.

Caitlin Collins – Altarum Institute

We have no more comments at this time.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay, so, again, thank you Scott, Judy and MacKenzie for helping us get through this. Scott, we look forward to having the workflow and then test procedure, I'm just kind of envisioning maybe three slides where we can kind of tell, or you can do one of the ones where it slides in and we can see it over the workflow scenario. And then some kind of process by which we can look at test data, so we can help you there and if you'll just, let us know if that's where you're going.

Scott Purnell-Saunders – Office of the National Coordinator

Yeah, we are. So that should be – like I said, be prepared for distribution Wednesday. Once we get the draft version of that built together, we'll try to circulate that to you guys.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. And then anyone else from the workgroup themselves or Cris that would like a question or comment.

Christopher Ross – Mayo Clinic – Chief Information Officer

This is Cris. Just as a checklist item also, nomenclature, glossary, and definitions I think are really important, and making sure that we scour through whatever documents we're producing and see that we're using language consistently.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. Anyone else from the workgroup or from ONC? Okay, and MacKenzie, do we meet again next Monday?

MacKenzie Robertson – Office of the National Coordinator

I believe we do have another appointment for next Monday.

Caitlin Collins – Altarum Institute

We actually do not have any other meetings for this group scheduled right now.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

Okay. Will you go ahead, I think we talked about it, but didn't, I think, affirm last time. We probably – with the workgroup's affirmation, I would like to keep our Monday meeting every week until we say stop.

Christopher Ross – Mayo Clinic – Chief Information Officer

I think it's a good idea Liz. Thanks.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

... MacKenzie.

MacKenzie Robertson – Office of the National Coordinator

Yup, we'll have those scheduled.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President

All right. Thanks everybody. Have a great Monday.