

HIT Standards Committee Implementation Workgroup Transcript February 4, 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 for Health IT. This is a meeting of the Health IT Standards Committee's Implementation Workgroup. It is a public call and it is also being recorded so please make sure to identify yourself when speaking. There is also time for public comment at the end of the agenda. I'll now go through roll call. Liz Johnson?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Liz. Cris Ross? 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? Tim Gutshall? Joe Heyman? David Kates? Tim Morris? Stephen Palmer? Sudha Puvvadi? Wes Rishel?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Wes. Ken Tarkoff? John Travis? Micky Tripathi? Gary Wietecha? Rob Anthony? Kevin Brady? Tim Cromwell? And Nancy Orvis? And are there any ONC 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, with that I'll turn it to you Liz.

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

Thank you. So this morning what we're going to do is, I saw...I'm sure many of you saw that the first scenario was released and we've asked Scott to give us...sort of walk through that, and we'll begin to get input from us, the public as we move forward. Because our mission if I understand it correctly Scott, is that once we get this one and we kind of understand what works and doesn't work, then we'll go on to others. Is that right?

Scott Purnell-Saunders – Office of the National Coordinator

That is correct. So our goal with the approach with this is to, one, because this information has been posted to the public and available for comment, to get the workgroup's feedback immediately on this, as we try to refine this over the next few weeks, to get this to a point where it can be released to the testing labs for use in the certification program. And once we get this one locked in, such that it is operational and consistent and reliable, we'll then begin work on other scenarios that we'll build, using this as a building block, along with some other approaches as well.

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

Great. Well why don't – are there any questions from the workgroup? All righty then Scott, let's get started.

Scott Purnell-Saunders – Office of the National Coordinator

Great. So, what we're going to do today is take a little bit of a different approach. I'm going to share my screen with the workgroup so if folks are able to hop on the webinar, please do.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Hey Liz, Dave Kates joined as well.

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

Hi Dave. Scott, can the public do that as well?

Scott Purnell-Saunders – Office of the National Coordinator

Yes ma'am, they can.

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

Great. Thanks.

Scott Purnell-Saunders – Office of the National Coordinator

So, for everyone who's on the webinar, what you're seeing currently is the 2014 test scenario webpage. So this is the overview page that was created that contains all the various documents that were released along with the test scenario procedure on Friday. I'm going to take a step back and actually go back to the first page that has this introductory link for everything, and kind of walk us through that. Hopefully everybody can see this now. So this is the first link that was created for our test scenario, it basically walks through the main reasons why we built the scenarios and you'll see a familiar diagram here in the blue box that compares unit-based testing to the scenario-based testing. We have listed benefits of a clinically plausible workflow, to better test data across systems and to test data within the system, which is the interoperability and intraoperability piece we've been discussing. We also indicated the value add for the scenario-based testing, the efficiency, the reduction in set-up that the workgroup really brought to our attention recently, as well as the ability to add in a lot more consistency and reliability and replication across the scenario developments.

From this page, I'll go back to where we just were, which goes through all the various documents that we built to try to explain the testing scenarios and the various approaches of such. Just bear with me for a second. So, on this page, you'll see a lot of various links, and there's a big header that basically states helpful materials. Under the helpful materials link is the overview presentation, which is a subset of the presentation, which was presented to the Implementation Workgroup over the last two weeks. We synthesized that down to about 12 or 13 slides that gives a fair amount of background on the test scenario development, where we came from, where we're going and the approach with how we were trying to work through this particular process. Along with that, there's a companion narrative. I won't go through the narrative because I can talk everybody through it, but the narrative is basically a script that goes along with the presentation. So, in lieu of someone actually being able to read the slides to you and work through them with you, you can use the companion narrative to walk through the various slides that we created to ensure folks understand our approach. And I'm opening up that original slide deck now, just to give everyone an idea of where we ... what this looks like, to give folks a starting point. As I said, there are 12 slides here and a big note on the bottom of the screen ensure that you do reference the companion narrative document when trying to work through this, if you haven't had familiarity with this previously.

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

Hey Scott ...

Scott Purnell-Saunders – Office of the National Coordinator

Yes Liz.

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

Why don't you pause occasionally and just make sure that if anybody from the workgroup – what we're really looking for, besides this content is also readability and usability. We had quite a discussion last week about even our ability to understand and to follow the concepts, given that we've been involved from the beginning, so, you may want to pause from time to time just to give people a chance to give you feedback.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. I certainly will.

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

All right, thank you.

Scott Purnell-Saunders – Office of the National Coordinator

So as we cont ...

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

Go ahead. I was just going to say, when he pauses, guys, if you have comments or again, think about not only usability, but also readability or understandability, whatever you want to call it, for someone who's completely unfamiliar with this approach.

David Kates – Senior Vice President Clinical Strategy – NaviNet

And the audience for this document is vendors or the community at large?

Scott Purnell-Saunders – Office of the National Coordinator

It's more of a hybrid approach so definitely vendors and the test labs, because the scenario procedure as we sent out last week maintains the same format from a technical perspective, that the other developed testing procedures did. The companion documents that we're building are more for consumption by the general public as well as vendors and providers, just to give them an idea of what the approach is. So we tried to make it – we tried to simplify it as best we could so that everyone would get a good understanding of where we were coming from.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So could you, out of all that, I wasn't sure – for this document, the target audience is, includes the general public or ...

Scott Purnell-Saunders – Office of the National Coordinator

Yes sir. It's the public at large, that's why we developed the companion narrative, too.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay. Thanks.

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

But realistically Scott, and correct me if I'm wrong, the people that will be using this are the certifying bodies and the vendors who have to test.

Scott Purnell-Saunders – Office of the National Coordinator

Yes, as well as the test labs, so the test labs will be presented with this procedure once it's fully qualified and edited by everybody involved, and presented for certification. The test labs then use that scenario in testing to test the various products that are being presented by the vendors. So the vendors would use that as a framework and the test lab would use it as a testing base.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

And the odd self-developed hospital ...

Scott Purnell-Saunders – Office of the National Coordinator

Right.

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

Right. Yeah, so somebody like ... yeah. So for our proprietary stuff and EDWs and that sort of thing, you're right ... or John Halamka will be using it himself.

Scott Purnell-Saunders – Office of the National Coordinator

Right. So, I'll continue with the presentation, there are – so, the contents are very similar to what we looked at last week, just to kind of give, you know, explanation of where things are. So, I'll continue on. The purpose of the scenario-based testing basically reiterates what we just talked about. One, to make clinically plausible set of scenarios that make sense in the clinical workflow. Our idea with that is it may not cover every scenario in every setting, but to do our best to make sure that it would make the most amount of sense in the clinical environment, to ensure the ability to test data across and within a system. That's the diagram that's depicted below, where you see the dark blue dots kind of floating around inside a system and then the larger arrow that connects two different systems. And as we talked about earlier, increasing the value of testing, improving the efficiency of testing, reducing the set-up. Like we said, that was something that the workgroup really brought back to us in saying that it doesn't require the replication of the unit-based testing over and over again, in that one set-up and one input of data from one test can be passed across. And that will make testing a little bit easier, hopefully, on the vendors...from the vendor perspective and then making testing consistent and replicable.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So I have a question, this is Wes. The dark blue dots ...

Scott Purnell-Saunders – Office of the National Coordinator

Yes sir.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

... are those intended to mean components of an EHR?

Scott Purnell-Saunders – Office of the National Coordinator

Yes, as more or less the information that's within that particular EHR ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

... so the data that's being passed within that same system. So not necessarily a particular test, just information.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So, data within a system is effectively – I mean, when I saw data within a system, I was thinking about, well, you put in this data and you look on the screen or you do this function, and you look on the screen to see what's happening, but it appears you're really talking about transmission among components of an EHR rather than what I was thinking of, is that right?

Scott Purnell-Saunders – Office of the National Coordinator

Yes sir.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay. So I would suggest instead of within a system, among the components of the system ... of an EHR, I mean it is – yeah, I would ... among the components of an EHR.

Scott Purnell-Saunders – Office of the National Coordinator

Okay, we'll take that into consideration. I'll write that down.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

It's just that system is a funny word, EHR is a funny word, given the component form of certification.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. Not a problem. Any other questions before I go on? Great, I'll move forward. This is just the unit-based testing overview slide. This diagram has been the same diagram we've used from the beginning, explaining that one, unit-based testing is the minimum required testing that's used. They are independent tests and that individual test data results in individual input and individual output for each particular test. We are currently employing these for the 2011 and 2014 edition test procedures, as required by the rules or statute and then they're required for the 2011 and 2014 edition testing and certification programs. Any questions here?

All right, I'll move on. Now we get into the beginnings of the scenario-based testing. As we talked about before, this is an alternative to unit-based testing; they are dependent tests in that the information that goes into one particular test would need to be used in a subsequent test following it. As we said, dependent test data for the data input and output, the individual tests can be removed from the sequence to create a scenario that would work best for a particular product, and that reiterates what we talked about before in that the scenario-based testing isn't defined in locked step for every particular product it would see. And then the fourth or fifth bullet is that the scenario-based testing is optional for the 2014 edition testing and certification program.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So, this is awfully late in our series of calls to be asking this question, this is Wes. How is it possible just to leave out a link and have the rest of the test sequence work?

Scott Purnell-Saunders – Office of the National Coordinator

So the idea was to build – we're building the scenarios in such a way that they are modular in development, so it's not – if a particular product can fit, you know, a scenario that will require say five or six different pieces, but one of those pieces it does not fit that particular product, that scenario can be modified or be able to be modified so that product would be able to work in that scenario. The design was not to say, you have to pick, you're going to have to make – I mean, it's as we laughed in the group, if you took all 49 test procedures and figured out every numerical combination of tests that would be required to test all of those in sequence or in some sort of sequence, we would not be able to get it done. It's not quite an infinite number, but it's extremely large. So the idea was to develop scenarios that can be flexible to test products that would have various needs.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay. Well if scenario one puts any data in that's relied on in scenario four or scenario two, then it's not going to work, right.

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

Yeah, that was my impression as well Scott. I mean, I don't know if you were doing modular testing, as I looked at this stuff when it came out on – why you wouldn't just do unit testing.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah. If every test is independent of what goes before it, that means that the data has to be entered redundantly, there's not – I don't know what the advantage is of being sequential in that case.

Scott Purnell-Saunders – Office of the National Coordinator

The idea with the sequential testing is that in building in each individual test to be pulled out is so that each test is auditable. So if a – you know, we do – if the very scenario is executed and a product goes through the scenario-based testing, there needs to be the ability to pull out the individual test results from each single test. So the idea is that with the scenario, you get the ability to test things within succession, but you still have the audit tracking of an individualized unit test. Because the scenario-based testing isn't required by – go ahead.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Go ahead, finish, I'm sorry.

Scott Purnell-Saunders – Office of the National Coordinator

Because the scenario-based testing isn't required by rule and statute, we still have to ensure that the individual test results can be seen and tracked properly. So, I hear your question on, well if one requires the data that comes out of three and four requires the data that comes out of one, how would you then isolate one out of the particular order, which is depicted here. The data set that we're building would allow some flexibility with that. You know, one thing that ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Give me an example of how it could work.

Scott Purnell-Saunders – Office of the National Coordinator

Umm.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Literally, I cannot see any difference between unit testing and scenario-based testing if in fact all of the data necessary for a given test has to be entered in the script for that test.

Scott Purnell-Saunders – Office of the National Coordinator

The data wouldn't be entered directly at that particular point. So say if a particular scenario was done, the data that was needed for the entire test or the entire series of tests would be entered at the beginning. Once it passes from say scenario three to then scenario one, the data from three would be reused in one, it's not re-entered, it would then be passed from one to the other. That goes back to the interoperability piece that we talked about earlier, so that you don't have that same setup breakdown, setup breakdown cycle as you have in all the unit-based testing. The one thing that we got from some vend, not vendors, but the test labs is that they already – some test labs are already building out these tests in succession anyway, based on how they have seen testing go. Our idea was to try to standardize how that was done. Certainly, we can't build and won't be able to build every exact scenario out, but the goal is to try to set up something that can start us down this path.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So ...

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

So one of the ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Go ahead, go ahead Liz.

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

I was going to say, one of the things we learned last week is we were questioning the same thing, we were questioning where were we getting any efficacy at all, and quite frankly, we were also questioning did we get the clinical benefit. But regardless, what we were told was the efficacy was coming from the fact that a single dataset could be entered and carried through all, and that in previous testing, they had to re-enter a dataset at each unit test level. I don't know if that makes any sense. It seemed to make sense to us, but like yourselves, we asked for an example because it's hard – it's one thing to follow it conceptually versus follow an actual set of data being used and entered one time and used throughout the scenario. And I'll give the floor to you.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah. So, if you make the assumption that all data that is entered for this sequence is entered in three, with the exception of any data that is entered and only used in a single test, then the example makes sense here. So maybe you're doing some testing on order entry and testing test unit three enter some orders, test unit one enters another order which is an error and sees a conflict and neither four nor two depends on the order that was entered in one; then that makes sense. I guess my concern is that the general implication of this document is that it's modular, that any test could be pulled out. It's clearly not true for the first test because it's entering the data for the entire scenario. It's quite possible that, I guess it's just a constraint on test design to say that any module, any test except the first could be pulled out. You know, you might ... I think that ... you know, the good thing about being old and having a short memory is that I get to repeat the experience of a new leader every week, and I feel like this particular slide is going to have a lot of difficulty in the community unless it's better explained.

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

Yeah, this is Wes, thank you. Actually, that's exact – and Scott, I think you continue to try and ... our ... sort of the ... because we have all struggled with ... we just don't know that the explanation even when talking to us can ... independently which means someone who's never seen it, is going to have difficulty getting it. It'll be interesting to see what kind of comments you get, Scott.

Scott Purnell-Saunders – Office of the National Coordinator

And that's the kind of, that's one of the reasons why we did it this way, was to get, to try to seek feedback from the group as we tried to walk through it again. Certainly the idea that Wes put forward with there being a question on the flexibility of the scenarios is that we've, we're designing this in such a way that the test can be removed, if necessary. It's not really, it's not a complete module, it's not that every test can be removed and that you end up with a scenario with just one test, that's simply a unit test. And that there are some dependencies, as has been designed into this. I mean, we're certainly starting this out as Carol called it, a proof of concepts, and doing this as best we can. But through this process, we're going to make a lot of refinements, based on the feedback we get, so, this is certainly helpful for us moving forward.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Scott, if you want to send me the deck, I can send back the suggested slide that would help explain it to me at least.

Scott Purnell-Saunders – Office of the National Coordinator

That's fine.

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

That would be great. In fact, the other thing that we asked, and we – Scott, at some point we really need minutes, so we can share it with previous – when someone's not able to attend every meeting, minutes would really help us. One of the questions we asked last time was, how many tests does this remove, meaning, if before by getting to the endgame it took 95 tests, and now it just takes 65, that helps us believe that we've actually created some efficiency. And Scott, that kind of thing will count, because when you look at it, I think we all get the first kind of got our visceral response which is, this is more clinically logical, but not necessarily removing any work whatsoever, and it should remove part of the work as well.

Scott Purnell-Saunders – Office of the National Coordinator

I mean, I think that at this point I understand that...that request, but as we're starting out, we don't – there's not really an expectation of how much reduction in work there's going to be, until we can kind of build a few more of these out. I mean certainly in the example we've done, we're able to really collapse say five particular unit tests, five unit tests down into one, so in that case you get a yield of four testing processes, but, it may not always be that efficient, depending upon the ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Have we actually had a chance to see that example?

Scott Purnell-Saunders – Office of the National Coordinator

Yeah, that's what we're going to get to shortly.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Oh, okay, great.

Scott Purnell-Saunders – Office of the National Coordinator

So, if there are not any other questions, I'll continue forward, and we can try to get to that example.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, go ahead.

Scott Purnell-Saunders – Office of the National Coordinator

Right. So the quick facts, I mean, that stuff we've covered initially, I won't spend too much time here. The components, the scope being a little bit more focused, the specificity, you know, not really being, not requiring a data specific setting and the scenario of the setting be determined by the test itself. And then the documentation. The diagram which we're about to get into, the procedure which is actually included as well, that we looked at last week and then the test scenario data, which is the new edition we were able to complete before posting this last week. So, I'll pause for a second and then kind of keep going. Great.

So, this is the conceptual overview document, what we've been discussing; and I'll take a minute to talk through this here. What you see depicted on the bottom of the screen are the typical combination of how information would flow in a scenario. So, if you look at box 1, that's identified by the number one in the yellow dot or orange dot, that's a test unit test procedure, so that would be indicative of one of the forty-nine that have been posted, that were posted in late December. The triangle that's beneath the connection between number one and number two would be the test for the data that moves from one to two has been added. Number two would be a different test criterion; number three would be a follow up test criterion and so forth. The line that's at the very bottom between one and two shows the combination of information that's needed for a scenario to work between test criterion one and test criterion two. You'd be testing test criterion one along with test criterion five, I mean test criterion two, excuse me, and the data passing between them would be indicated by the number five. That same process or procedure would continue between all of them. When you look at the combination between test criteria one, two and three, you have those combinations plus data included in step five and step six, and that process continues forward.

The yellow, excuse me, the blue test is one particular setting and then the ... is indicated by both settings, the green is inpatient and then the pink or purple is ambulatory. So if you look at the boxes on the far right hand corner of the screen, one would be indicated by 4a and one's 4b, I think the 4a's just not showing up right now in the particular diagram. But I'll pause for a second here, because I know this is a bit much to take in.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay. Well this is actually the diagram I was going to suggest. So, I – should there be a triangle between, a triangle showing one and two before box 1? And here you're showing, I mean, what you're showing is that every box inherits the data that was entered in a prior test

M

Before one?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporate

And here you're showing – I mean, what you're showing is that every box inherits the data that was entered in a prior test, obviously except those where the test calls for deleting data, and requires additional data. And the triangle represents the incremental data that's added, whereas the line that comes up from the bottom represents all the data that would be added for a step. So for example, for Liz's question about savings, for test two, we can save the numbers one and two from below, for test three we can – I guess I don't understand where all these numbers, what do one and, what's the difference between one, the lines that come up from below the tests and it talks about, for the one below box two, it talks about 1, 2 and 5.

Scott Purnell-Saunders – Office of the National Coordinator

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

How is the data – so I assume that means one is data entered in test one...

Scott Purnell-Saunders – Office of the National Coordinator

Correct.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Two is data entered in test two and five is data – how is it different than data that would be entered in test one or test two? I mean ...

Scott Purnell-Saunders – Office of the National Coordinator

So if there is, if there was specific data that needed to be added by test two for that test to occur, it would be added there. But in most cases, the test data that we're designing, would not require additional data unless necessary. The idea with the savings in this case would be this ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, I understand all that. But, just the nomenclature here.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

The two ...

Scott Purnell-Saunders – Office of the National Coordinator

... is a test procedure.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

The two in the orange box identifies a test procedure.

Scott Purnell-Saunders – Office of the National Coordinator

That's correct.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

The two on the line below it ...

Scott Purnell-Saunders – Office of the National Coordinator

Is the same. So it's saying that ... that line indicates the test procedure from one combined with the test procedure from two and the data that was added in step five. So the data coming out of procedure one goes into test criterion two. That's what the five is the combination of all that together.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I'm sorry, but you've got data that you entered in one, you've got data that you entered in two, and you've got data identified in five, what's the difference between the data that's entered in two, that's listed, that's indicated by the number two, and the data that's entered for two that's listed by the triangle named five. I mean, why are there two different sets of input data just for test two? You know it's got to carry forward from one ...

Scott Purnell-Saunders – Office of the National Coordinator

Right, but it's just – we're calling that out, that there is data that's passed from one to two.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So ...

Scott Purnell-Saunders – Office of the National Coordinator

So instead of ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Is five the data that's passed from one to two?

Scott Purnell-Saunders – Office of the National Coordinator

Yes.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Five is not data that's entered new, it's the data – then why doesn't this just say 2 and 5 below two, why does it say 1, 2 and 5.

Scott Purnell-Saunders – Office of the National Coordinator

Because it's still calling out that data came out of one into two and was included ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So it's calling out the data that comes between one and two twice, once as number one and once as number five, is that correct.

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

That's right.

Scott Purnell-Saunders – Office of the National Coordinator

We didn't look at it as being counted twice; we just tried to indicate that the test criterion was there. But if there is a confusion there, we'll try to clear that up.

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

There is a distinction between the unit test of orange one going on all by itself and then the fact that the data that was entered in orange one was actually carried forward into orange two. That's the distinction and the reason for the call out of five.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Could you repeat that Anne?

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

There's a distinction between orange one being just entered into the system as a unit test and the carrying forward of that same, exact data to be used as the beginning layer when number, when unit test two is performed. So five is representing the carrying forward of that data into unit test two.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I understand that, I just ...

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

So he's just ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

... don't understand why there's a one on the line that goes into the bottom of unit test two, because the data from one that's entered in for test two is identified by five?

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

So it would be simpler to just say 5 and 2.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I – that's my point.

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

Got it.

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

Yeah, exactly. And the other thing you could do Scott, is if you actually took a data element – I mean, part of the problem is you're trying to use numbers and maybe you have a further diagram that, it's again, you know, I agree with what's being said and again you're trying to use numbers to represent data, and that's difficult to understand ... ever seen it.

Scott Purnell-Saunders – Office of the National Coordinator

That's fine. I think we'll get to that, but I'm definitely taking that and we'll try to refine this as we move forward.

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

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

So, this is the ...

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

Before you move forward, are you agreeing with us that by adding the number one that you're causing confusion?

Scott Purnell-Saunders – Office of the National Coordinator

No, I mean, if, I understand, because I'm – I have been so close in development with it, I understand where you're coming from, and I think we're going to take that to heart and try to better explain it. Certainly, I think the one is confusing there, but...

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

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

... but I think, and I'll give a bit of our perspective with it, the idea was to say, for example, if we just looked at step two or just – if we remove one from this particular documented combination of document, we didn't want to lose what came out of criterion one, to show that ...

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

You don't because ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

But that is five, right?

Scott Purnell-Saunders – Office of the National Coordinator

I understand, I'm just explaining why we left it there. We weren't trying to do it to confuse people, was to just make sure we indicated that it is a combination of those two test criterion.

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

Yeah we know we can only push you so far Scott, but we're just trying to get you to acknowledge that you would seriously consider removing one.

Scott Purnell-Saunders – Office of the National Coordinator

Oh, I certainly have.

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

Okay.

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

Okay Scott, we've spent so much time on this same picture on every call...

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

That's right.

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

And you haven't budged at all. Just an observation.

Scott Purnell-Saunders – Office of the National Coordinator

From the call last week to what we got to Friday, there were a lot of changes, trust me. This is one on the back burner to get done, so we will definitely make changes to it.

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

You know Scott, one of the things we may want to consider, and this – we'll watch for public comment and see where we land. Sometimes though, I know this is very difficult but it takes sort of blowing it up and re ... coming up with a new visual, because like Anne pointed out and I think all of us have pointed out in our own way, we have struggled and struggled and struggled trying to get there with this one. So, is it the right format, is there a different way to show this.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

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

Okay?

Scott Purnell-Saunders – Office of the National Coordinator

Yes ma'am.

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

So we're looking for you to get creative and maybe have something different next week.

Scott Purnell-Saunders – Office of the National Coordinator

No pressure, right?

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

No pressure. Okay, we'll move on. Thank you.

Scott Purnell-Saunders – Office of the National Coordinator

Not a problem. I love you guys. So, all right. This basically takes what we've been talking about from a conceptual step and tries to move it a step forward in a ... and then taking it to a technically clinically plausible workflow. This is a new diagram that we hadn't introduced before, but it tries to look at one of the...the way we developed the scenarios last year, as far as the narrative and tries to develop it into a step further. So, we will start in the upper left hand corner where you have your ambulatory inpatient and as depicted by the box, the patient is seen by provider (ambulatory) or admitted to a hospital (inpatient). The med, med allergy list and problem list is then carried to, as we're talking through steps one and c, those are indicated by the three test procedures called out here, (a)(6) was the medication list, (a)(7) by the med allergy list, (a)(8) by the problem list, and we're calling out 1a through 1c as we'll follow through the same numerical combination moving forward.

So during the visit the med, med list, med allergy list and problem list are recorded, changed and accessed in the EHR and then that's sent to the upper right hand corner, the physicians or hospitals EHR for that particular step. From that EHR, that med list, med allergy list and problem list are then carried down into test procedure two, which is the clinical info reconciliation piece. During the incorporation of the C-CDA, which is coming from the bottom, clinical info reconciliation is performed between the med, med allergy and problem list stored in the EHR and that was contained within the C-CDA. From the lower left hand corner, you'll see that the patient is referred to provider upon discharge in ambulatory or admitted...from a recently admitted hospital visit and then the EHR comes from the bottom. The C-CDA that then came up into step two was created during the step in 1d, during the transitions of care, the referral summary was then received, displayed and incorporated into the receiving EHR. That's then added into step two with the information that came down from steps 1a through 1c. Once the info reconciliation has been completed, the med, med allergy and problem list, which has been reconciled, is then sent back to the patient, the physicians or hospital's EHR to stop the process. So I'll pause for a second, since that's different than we talked about before.

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

Wes, Dave, and Anne, I don't have it in front of me, so if you guys would...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah. It's just so small, it's hard to...I've got my nose to the screen here trying to read it...

Scott Purnell-Saunders – Office of the National Coordinator

I'm sorry, I got it as big as I can have it here. Let me see if I can – does that help at all for people?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, that's a bit better.

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

Better.

Scott Purnell-Saunders – Office of the National Coordinator

Okay, so this is the top half, I do apologize because we're sharing a screen, so that the first half basically shows the steps 1a through 1c with the med, med list ... med allergy and problem list.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Is there some way I can make it bigger on my, I can zoom in on my end, I guess...

Scott Purnell-Saunders – Office of the National Coordinator

Can you hit full screen on yours?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Well, I guess that's part of the browser, huh? I don't see a full screen button on the ...

Scott Purnell-Saunders – Office of the National Coordinator

Yeah, so I'm sorry, I guess because I'm using the browser, it has that at the top.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, okay, so, I ...

Scott Purnell-Saunders – Office of the National Coordinator

Hold on, maybe – yeah, I can't use full screen either. I'm sorry.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, no – so, the red arrow, the sequence here is meds, med allergies and problems are entered, you can see them on the screen ...

Scott Purnell-Saunders – Office of the National Coordinator

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

There's a process called reconciliation that is tested. Generally, reconciliation should have something that causes – well, there should be data already in the EHR that is different than the data that's entered through 1a through 1c, otherwise there's nothing to reconcile.

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

Yeah Wes, there could be a secondary piece to that which you may be getting to, which is also what is in the C-CDA. I mean I can't – are you, Scott inferring that the meds, problems, allergies, those are already in the system and we're reconciling what the patient is telling us on admission, are you saying we're reconciling it against the C-CDA, which comes over?

Scott Purnell-Saunders – Office of the National Coordinator

So in this care, yes, there is the assumption that there's already data that's in the physician or hospital's EHR. And what they're getting at this particular point is from the patient interaction, whether it be during the initial visit when they're seen by the provider or hospital, what happens upon discharge. So in steps 1a through 1c, the data that they're receiving that we're indicating by the med, med allergy and problem list is what's being given by the patient and then combined with what's in the system. And then in the bottom, with depiction of the picture, it's what was received upon discharge from the ambulatory or inpatient visit.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Since you said it twice, I want to just double check, isn't meds reconciliation normally done on admission.

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

Yes and that's what the measure is against, is admission.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay. So, the – I think it happens at discharge more than we'd like, but, the ... so I think the steps make logical sense here, all right. There is some data in the EHR, more data is received from the patient, the two sets of data are ... and so, steps 1a through 1c would emulate entering the data from what the patient says. Step 2 represents reconciling the new data with the EMR. Now there's a triangle here in the middle that says 3-5. I don't know what that refers to.

Scott Purnell-Saunders – Office of the National Coordinator

That's the call-outs of the previous diagram that we looked at before.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I see. Okay.

Scott Purnell-Saunders – Office of the National Coordinator

So basically we look at 3-5, and I'll go back a step, and the call out on 6, that's the data that's there, so essentially 5, 6 are here and 7a and 7b, that shouldn't, that necessarily isn't 3-5, that should be just, you know ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

It's based on the numbering from the other diagram, I mean ...

Scott Purnell-Saunders – Office of the National Coordinator

(Indiscernible)

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So it should be ...

Scott Purnell-Saunders – Office of the National Coordinator

The numbering is off here, we'll make sure that gets fixed.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay. All right. So, step 2, if I understand this, the verifiable end result is the reconciled med, med allergy and problem list still in the first EHR. And then, if you scroll down, I guess I ... now since you made it easier to read the letters, I can't see the bottom, can you sort of scroll up a bit.

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

Yeah, go to the other half of the screen.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah. Okay, I hate it when it does that. Good job. All right. So now, so in the bottom left, it says, patient is referred to provider upon discharge (ambulatory), you don't discharge from ambulatory, well you do, but it's not called that, or directly admitted to the hospital from provider (inpatient). Okay. Oh, I see, patient is ... this represents the transition of care, so ... patient is discharged from the hospital and referred to a provider or, the patient has seen a provider and is admitted to the hospital. Okay, that...it's not very clear there, but it does make sense. Now, there's an arrow next to the number 6 which implies that the med, med allergies and problems are going to the physician's EMR, as labeled at the bottom, but of course that would either be the physician's EMR or the hospital EMR, according to which of the two scenarios you're doing at this level.

Scott Purnell-Saunders – Office of the National Coordinator

That's correct.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

And the arrow seems to me to be going in the wrong direction.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. So from that, the arrow is coming out of that EMR/EHR into the clinical info reconciliation, where that reconciliation is done in step 2. So, in same vein that it left the computer in the upper right hand corner of the screen and came down to step 2, it's doing the exact same process to be reconciled in step 2 there.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay. So – ah, this is an important diagram because it's explaining the overall workflow that goes behind the testing and that's critical we have...I think it's definitely on the right track. But it's important to recognize that the dialogue in the lower left corner, patient is referred to provider upon discharge, physician's EMR, does not represent a testing step, it's the assumed context. The testing step is to send the CDA back to the original physician or hospital's EHR. Okay, so ...

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

Can I ask a question?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah.

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

The bottom left, is that before or after the top left?

Scott Purnell-Saunders – Office of the National Coordinator

It's bef – it could happen simultaneously.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Well, it's not logical, the patient can't be in two places at one time.

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

Yeah, that's ...

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

I'm ... this out with too much information ...

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

Well I'm wondering if that should be – I'm wondering if it should be sequential, because you're right, it can't do it, it's not concurrent, it's sequential.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Well, I think, I think if you just kind of put your hand over that stuff in the lower left corner ...

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

Can you generalize and call it prior visits?

Scott Purnell-Saunders – Office of the National Coordinator

I can.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah.

Scott Purnell-Saunders – Office of the National Coordinator

I mean I guess because the idea was that it is ... you would ... the logical step is to start with the upper left hand corner and continue through. But if, for example, a patient has a referral that exists and then is seen by a provider, I mean, in my own head, and I could be wrong here, the step that happens in the lower left hand corner could happen and the step in the upper left hand corner could happen immediately following that, for the reconciliation to occur. It's not ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Well I think there's only one ...

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

If there's any prior visit, that accumulated some clinical medical record, needs to be input and reconciled with a current visit.

Scott Purnell-Saunders – Office of the National Coordinator

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, I would suggest that this would be a lot more intuitive if 1d was at the top instead of the bottom.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

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

Why don't you – Scott, if you can give that a whirl so we can look at it our next meeting, and if you can get it out to us, because we almost have to go to comment now. If you can get it out to us ahead of time, so we can look at it before the meeting that would be terrific.

Scott Purnell-Saunders – Office of the National Coordinator

Okay. Let me – that's fine. Let me go to the next slide and I'll try to, we'll try to retool this so it makes, it flows a little bit easier.

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

Okay. One more slide.

Scott Purnell-Saunders – Office of the National Coordinator

Yup. So basically, this talks through what we just went through, and we don't have a ton of time to talk through this, but essentially this is the, more the narrative explanation of the diagram and workflow that was just seen. So, I would just ask the workgroup to look at slide 7 in combination to what we talked through with slide 6. We'll certainly work to try to retool 6 as well, and try to get some revisions back out. I mean, this is currently up for public comment, and I'll be working with the team to try to figure out, as we receive comments on the slide deck, what an update process and procedure would look like. But please, and I'll make sure I send, email the link out to the workgroup immediately following the call, so that the entire group can see all the documents that have been added to that so they can access them when you need to.

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

Okay.

Scott Purnell-Saunders – Office of the National Coordinator

And I'll let you go to public comment.

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

MacKenzie.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

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

Rebecca Armendariz – Altarum Institute

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 *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

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

Thank you. Thank you Scott, we know we're putting you through the ringer, but we hope that by the time you get us to the place where we understand it and the public gives you comments, it'll be in a better place for use. How long is the comment period?

Scott Purnell-Saunders – Office of the National Coordinator

I think probably for the next couple of weeks, we didn't have a defined timeline for that yet. The idea was just to keep it open while we try to make our revisions to try to get a more definitive version of this out by the end of the month, as best we could.

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

Okay. So, if you will reflect our comments, as you will, as well as let's say comments through Thursday, and then get us out a document on Friday so that Monday we can start with ... not start over, but start with what has been updated. In other words, we're not going back to the same slides again, they've been modified. And I understand that you've got to keep it public, but this is a public meeting, right.

MacKenzie Robertson – Office of the National Coordinator

Yes.

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

Okay. Any other closing comments from the workgroup, and thank you for your help this morning. All right, well everybody have a good Monday and we'll be talking again in a week.

Scott Purnell-Saunders – Office of the National Coordinator

Thanks for your time.

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

Thanks, bye.