

**HIT Standards Committee  
Implementation Workgroup  
Transcript  
February 25, 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 HIT Standards Committee's Implementation Workgroup. It is a public call and there is time for public comment built into the agenda. The call is also being recorded, so please make sure to identify yourself when speaking. I'll go through the 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?

**Christopher Ross – Mayo Clinic – Chief Information Officer**

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?

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

I'm here.

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

Thanks John. Timothy Gutshall? Joe Heyman? David Kates? Tim Morris? Stephen Palmer? Sudha Puvvadi? Wes Rishel? Ken Tarkoff? John Travis? Micky Tripathi? Gary Wietecha? Rob Anthony? Kevin Brady?

**Kevin Brady – National Institute of Standards and Technology – Group Leader, IITL Interoperability Group**

Here.

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

Thanks Kevin. Tim Cromwell? Nancy Orvis? And if there are any ONC staff members on the line? If you could please identify yourselves.

**Scott Purnell-Saunders – Office of the National Coordinator**

Scott Purnell-Saunders.

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

Thanks Scott. Okay with that, I will turn it back to you Liz.

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

Great. Good morning everybody. I think this morning our diligent work, and I'm sorry that Wes isn't here, but we all know how much, what gratitude we owe him. We should be able to go through the 2014 edition test scenarios. I think what Scott has done is combine both Wes' work and the work that had been previously done by this group, to get us to what we're hoping is a final version. And then, for those who were on the line earlier, as Cris was talking about, we'd like to talk about the next year's plan out of the Standards Committee and the role of the Implementation Workgroup related to that. And so, I think we've got our hour absolutely packed. Cris, anything else?

**Christopher Ross – Mayo Clinic – Chief Information Officer**

No, let's get to it. Thank you.

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

All right, you bet. So Scott, will you start to take us through please?

**Scott Purnell-Saunders – Office of the National Coordinator**

Certainly. Let's open the test scenario overview slide deck. Thank you. So slide two is just the updated content slide. As you'll notice, the deck has gotten a little bit longer, we took a lot of Wes' direct inputs and added them to the slides to try to make it a little bit more clear and transparent and less require, less requirement on inferring information from previous versions. So, it should be a lot more clear moving forward. Next slide. Great, so this is the update to our unit-based testing deck. As you'll see, there are a lot of ... some very thick lines between unit test A, B and C, which basically parallels what we've been discussing and describing. The current testing environment, where a single test exists by itself and then another test is done after that and so forth, to indicate that there is no sequence as follow with each of these and each of those are done essentially in a vacuum, by themselves. Any questions here? Great. Next slide.

So this is the beginning of the unit test description that Wes built last week, or was presented from Wes last week. Basically, as indicated by the colored boxes, so you have your set program to initial state, the unit test being in the center. Any test data that's entered at the very top during the test, test data being verified during the test on the screen, by the reviewer or any other testing proctor or procedure. And then the information coming out the right hand side of the unit test as indicated by a big arrow, and the test is then set to a post-test program state. The indication of a thicker arrow just kind of shows that initial, additional information was added to the information that was initially presented through the unit test, so there's an increase in data from the beginning to the end of the individual unit test. And also after the test, you'll see the end state for the program, then the extra data and the unit test results are all the products of that particular individualized unit test. Any questions here? Great. Next slide.

So this is where we get into the sequence of two unit tests performed one after another. This is the basis for how we would start to describe a testing scenario. As you will, as compared to the last slide, the single – each single unit test is exactly the same with the difference being the outputs from Unit Test One and in the input to unit test two. So you'll see that the – all the output seen at test one, the data and the end-state are then combined and then sent to unit test two within, as a part of that initial program set-up to be built into the initial status and then the unit test one results just are recorded as were indicated in the single unit test. At the end of unit test two, it's exactly the same as it was at the end of the first unit test initial description. With the test results, we added file cabinet to just to kind of show that those results are filed and saved for use after the testing has been completed, and then the end-state and then the data are then grouped together as well.

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

Okay, so Scott, I am totally confused on this one. So we are saying that we go through unit test one ...

**Scott Purnell-Saunders – Office of the National Coordinator**

Correct.

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

... and it produces some output.

**Scott Purnell-Saunders – Office of the National Coordinator**

Correct.

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

But then we're saying we do not use that output for test two.

**Scott Purnell-Saunders – Office of the National Coordinator**

That's correct. So that's saying with the test being performed sequentially, it's only one unit test happening by itself and then a second unit test happening here. What we're trying to show is the build-up to get into the actual testing scenario piece, where tests are done ...

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

So in essence you're saying, this is current state.

**Scott Purnell-Saunders – Office of the National Coordinator**

Correct.

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

Okay, we might want to – so, I don't – if I'm the only one confused by that, please say so, but I guess maybe because I'm looking toward this being new, or, I'm trying to read it like I haven't seen it before. Is everybody else on the phone would have understood that, then please ignore my input.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Well Liz, I agree with you, I think you're right. The only question – this is Cris – the only question I've got is whether we want to label it current state or if we want to label it something like, you know Scott, discrete tests without scenarios, where these are independent unit tests.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Which is what we did in Stage 1, right?

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

Right.

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

Can you just add the word independent after the 2 on the title?

**Scott Purnell-Saunders – Office of the National Coordinator**

Sure.

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

Okay.

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

Yeah, I just – to me and so Anne or Cris or John or anyone, please help ...

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

No, I'm with you. This is Anne and I was trying real hard to get a scenario out of it by just going to the picture without reading the words.

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

Right. Yeah I just think the box at the bottom that says the post-test program state of unit test one is not used for the initial state, it's like, I mean, I have to tell you, when I read it I kind of go, well why would I expect it to be.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

Are the arrows a problem, the dash arrows? They imply a connection and I was getting two-way connection out of it because of the two arrow heads.

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

Yeah.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

Me too.

**Scott Purnell-Saunders – Office of the National Coordinator**

All right, we'll refine that. Great. Thanks a lot. So this slide is the same as we've had it before ...

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

Right.

**Scott Purnell-Saunders – Office of the National Coordinator**

... so with the data across system and the data within the system, so that's not new.

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

I think we just have – we get done at the end of the day, got to make sure we accomplish this purpose.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay. Next slide. So this slide basically starts to describe what the scenario-based testing is, as you can see, it's just words here, no descriptors, no graphics, to try to build up a little bit slower than we have been. So we wanted to – alternatives to unit-based testing, they are dependent tests and they're optional for the 2014 Edition Testing and Certification Program. Next slide. So this is the new slide that we built based on Wes' input from last week, showing the first version of a scenario-based test sequence. One...as you can see, first we set test 1 and then test 2. You set test 1 to initial program state, data is then input at the beginning, data is inserted during the test, as indicated by the triangle above the unit test 1, and then data is verified out of the test, which is indicated by the arrow coming down to a different data box. As you can see moving forward, the arrow coming out of unit test 1 is red with the unit test results. The set post-program state is then essentially not done, which shows the difference between the, as we can call it, the two single unit tests that we showed in the last diagram versus this one. We see a big red arrow continuing to unit test 2, and then the data being entered during test 2, the data coming out at the bottom and then the unit test 2 results coming out at the very end with the post-test program state being set up again and the end state and the data. And then we'll say, as a call out it says excludes data carried forward from test 1, as a call out there, it's not necessary.

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

I just have a couple of questions. On the – why – and I have a question about the previous slide, so I'm going to go back. First, I wanted to touch on this one. Why do we say excludes data carried forward from test 1, I don't – why do we say that? I thought they built on each other.

**Scott Purnell-Saunders – Office of the National Coordinator**

No, they do build on each other, but it's showing the results, so essentially the test 1 results are independent.

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

Where does it show results, how do I know this is results?

**Scott Purnell-Saunders – Program Analyst at US Department of Health**

So Unit Test 1 results are indicated by the yellow bubble coming out of Unit Test 1, then that's carried – those are then carried into test 2, but can be verified separately, which is ...

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

Okay, well if that's the case, then the call out box, the dialog box so to speak should be pointing to the results box and not to the unit test 2.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

I think people will still be confused by it, but at least that's what – I think that's what we intended, thank you.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

Jon, Cris, and Anne, are you seeing it the same way.

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

Yes.

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

Okay. Now Scott, I wanted to go for – back to just a moment. When we start into the purpose of the scenario test training and then when we say it's an alternative, we don't really say what it is. I mean we sort of – I mean, you could just say on the slide 7, will be scenario-based testing will be described in the following slides or in the following graph of the slides or something. But you kind of go from here's the purpose, here's what it's an alternative to these other things, but you don't say what it is.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

And, this is Anne, can you tell me, I'm missing it. What are those little blue dots?

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

Yeah, I couldn't figure that out either, that's a good catch.

**Scott Purnell-Saunders – Office of the National Coordinator**

They were basic call outs to having a numerical order for one, two, three and four. We added them there because in the later versions of the actual diagrams, you'll start to see those numbers, for individual steps as we get to the actual test scenario diagram for the procedure that was done.

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

What slide will that be on?

**Scott Purnell-Saunders – Office of the National Coordinator**

I think it starts about slide 11 or so. No, I'm sorry, it starts on slide 13, when we start adding for the individualized test procedures, so that's step 1a through c, then step 2 and then 1d, as we talked about ...

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

I just wasted a lot of time trying to figure out what they meant.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

Yeah, I also – I've printed your handout twice and mine jumps from 9, 10 – from 10 to 13. Did everybody else get 11 and 12?

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

No, I didn't either.

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

So when you say it moves there Scott, I don't have those slides.

**Scott Purnell-Saunders – Office of the National Coordinator**

Oh, okay. Sorry, I'm like ...

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

That was a happy sound, Scott.

**Scott Purnell-Saunders – Office of the National Coordinator**

No it is, because I'm looking ...

**Christopher Ross – Mayo Clinic – Chief Information Officer**

I got 11 and 12 from what was sent out the other day, I have it.

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

Oh, I pulled the latest one because I figured that was – should I go back to Friday?

**Scott Purnell-Saunders – Office of the National Coordinator**

Yes.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

That's the one I'm looking at.

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

Okay.

**Scott Purnell-Saunders – Office of the National Coordinator**

Where's the latest one you got it from, did you pull it off the website?

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

I pulled mine from, hang on a minute, I just printed it ...

**Scott Purnell-Saunders – Office of the National Coordinator**

Because – the Friday one was the latest one we sent out, that was the one I was going to try to use today.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Well now mine just goes from 10, 13, back to 12 – at least the numbers on the bottom.

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

Oh, is this out of order – oh, that's what it is – no, and there is no 11. It's like ...

**Christopher Ross – Mayo Clinic – Chief Information Officer**

There is no 11. It's out of order and there is no 11.

**Scott Purnell-Saunders – Office of the National Coordinator**

Uh oh, sorry.

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

So we do have the same version.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Yeah.

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

Yeah, I was going to say, this is what I'm looking at.

**Scott Purnell-Saunders – Office of the National Coordinator**

I don't know how what I sent is not what I'm looking at since I'm looking at the same version, but I'll blame on it email for the day.

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

What's the one on the Web ...

**Scott Purnell-Saunders – Office of the National Coordinator**

That's from like a couple of weeks ago, so we haven't – we're going to update that based on everything, all the feedback we get from today.

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

Okay, well, somehow Scott we need to get one that's in the order that you want it to be in, I think we're with you, through eight we're definitely with you, other than the fact that we don't need scenario. And I'm like Anne, I couldn't figure out the blue circles and I'm not sure they make any sense until you introduce them. I don't think you're helping.

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

Well, in the package we have, they're never introduced, because of that missing slide.

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

Right. Right.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay. So give me a second ...

**Christopher Ross – Mayo Clinic – Chief Information Officer**

They're beautiful though.

**Scott Purnell-Saunders – Office of the National Coordinator**

Thank you.

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

Virtually symmetrical blue circles ...

**Scott Purnell-Saunders – Office of the National Coordinator**

I do appreciate the comment on the clarity and the color, so we like that this morning. Let's – honestly, give me a second – it's a numbering issue at this point, I do apologize for that, I'm sorry ...

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Are they automatically numbered or you had a glitch in your program?

**Scott Purnell-Saunders – Office of the National Coordinator**

We'll call it a glitch in my program. We automatically numbered them and then changed the order and I thought I updated the table of contents, updated table of contents, but didn't change the slide numbers ...

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

So based on that, we're just going to assume the order we're in is the correct order, it's just misnumbered ...

**Scott Purnell-Saunders – Office of the National Coordinator**

That's correct.

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

... the blue circles never show up again.

**Scott Purnell-Saunders – Office of the National Coordinator**

Right, that's fine. So, I'll take those out and call them up in a better way moving forward. But more than likely, I'll delete them from there.

**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 let's go to slide 9. Slide 9 introduces the multi-test scenario where more than one unit test are kind of strung together. Basically, this is the diagram that Wes introduced last week. So we added the individual information showing the setting program to initial state and showing how the data would pass through each individual test and showing how the data would pass through each individual test and after the post-program state, all the data's been verified and then put into a filing cabinet for use later.

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

The only think I see on this one is just a typo. I think under test 3 you meant incremental data entered during test 3.

**Scott Purnell-Saunders – Office of the National Coordinator**

That's correct.

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

Okay. Otherwise, this one makes sense to me.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

Other folks?

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

I'm good.

**Scott Purnell-Saunders – Office of the National Coordinator**

Great.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Okay.

**Scott Purnell-Saunders – Office of the National Coordinator**

Next slide. Great. So this is the optional test slide. The biggest thing we changed from Wes' version was the arrow color change under unit test 3, to show that there are two independent paths that happen there, so you can either opt to go through test 3 or opt not to, which is indicated by the red arrow. But it keeps the same, and again, we've got to change the typo under incremental data entered during test 2, which needs to be changed again. But, it shows how you can run through unit test 1, 2 and then go directly to 4, or go through 1, 2, 3 and then 4.

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

This one works really well, I think. This is very helpful.

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

I agree.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay. All right, next slide. So ...

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

This one says 13, but you meant it to be 11.

**Scott Purnell-Saunders – Office of the National Coordinator**

That is correct.

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

All right.

**Scott Purnell-Saunders – Office of the National Coordinator**

So this just goes back through some of the quick facts that we've talked about and kind of raised through the diagrams over the last few slides and kind of just reiterates kind of what the components are with the scope, the specificity and then the documentation. The – as we talked about before, there is the actual Test Scenario Procedure that's on the website that we'd like to get people to look through, so they can actually see what's there and then see an actual version of the test data that will be used to operate this procedure. Next slide.

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

So I'm just going to stop you for a second, when you get ready to redo, before you get into, let's see, on slide 7. I don't want you to repeat the same thing, but you need to tie sort of the beginning and the end of what a test scenario is together, okay? Because remember what we said was up on 6 you talk about the purpose, on 7 you talk about what it isn't – oh, that it's an alternative, but you never really have a lead-in as to what scenario-based testing is. And then here you just have some quick facts, that really again, don't really say. I mean, it's two or three lines, it's the combining of unit tests without the elimination of the – you know, the sacrosanctness of those, into a clinically based workflow. And that the visios or whatever you call them, the diagrams that follow explain how it works; something like that.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

And Liz, I'm doing this from memory, I looked at this this morning, but, is there someplace in here where – I agree with everything you're saying, because I thought it was missing, but a piece that says, what's the benefits that we hope to derive from this.

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

Yeah, it's on slide 6.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Okay, thank you.

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

You bet. So, I think before you get to 6, you really have to say what it is, Scott.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

And then you may be able to combine 6 and 8 together, and then have the benefits on – you may need to make slide 6, what is it and slide 6 and 7 might be able to be combined or the stuff on 7 might be able to combine into the definition, and then you can go forward with your diagrams.

**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, now we're to what is currently marked 12, which I think is more like 11 or something.

**Scott Purnell-Saunders – Office of the National Coordinator**

Yeah, it would be 11 unless we combine the two slides.

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

Yes.

**Scott Purnell-Saunders – Office of the National Coordinator**

So this is the transition slide going from the, excuse me I had a hiccup, the scenarios that we were describing and the actual one that's been developed currently. So, the current scenario is the EHR interoperability intake. The links that are embedded in here, one link to the draft test scenario that's on the website, the overall Web page, excuse me, then the scenario procedure that actually has that fifty or sixty pages we talked about a while ago. And it shows what criterion are currently linked in the scenario, which is problem list, med list, med allergy list, then then clinical info reconciliation and then transitions of care, and then the overview materials as well, which would then link back to this presentation once on the web. And it shows, at the bottom of the next three slides, we're going to talk about the structure and narrative of the EHR interoperability test procedure that we've developed so far.

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

Okay. Okay, good. And then you want to talk about whatever slide number this is now as the actual workflow itself.

**Scott Purnell-Saunders – Office of the National Coordinator**

Right. So this is the clinically plausible workflow. So, go to the next slide please. This is more of pictorial view what the, what's contained in the workflow, showing as we start in Start A, patient seen by provider, now whether it's ambulatory or in a hospital setting, and then what happens at each particular step. So we go from Start A to what happens on the visit. So the patient data, including the med list – medication list, and allergy list and problem list are recorded and then changed and accessed in the EHR. That's called out directly with Steps 1a or – sorry, for certification criteria 1(a) through 1(c) on the right hand side for med list, med allergy list and then problem list.

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

Okay, stop there for just a second. Okay, why are we saying and, because it may or may not be changed. Can we not say is recorded, changed and/or accessed?

**Scott Purnell-Saunders – Office of the National Coordinator**

We can add or there.

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

Okay. And the second question I was going to ask you was why do we use the word plausible? I mean vers – I mean, I'm not try – I'm trying to understand why didn't you just say clinical workflow, what was the purpose of plausible?

**Scott Purnell-Saunders – Office of the National Coordinator**

To indicate that it may not work in every clinical setting. I think we've had some ... discussion with just saying it's a clinically based workflow or saying it's a clinical workflow ...

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

Well I would say clinically based is better than plausible.

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

Yeah, because plausible people will think, well it is or is not all the time.

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

Right.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

Agree. Thank you, John. Okay Scott, sorry to interrupt you, but I was trying to catch it before we got further.

**Scott Purnell-Saunders – Office of the National Coordinator**

That's fine. Just give me a second to capture that.

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

Sure.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay. So, we continue through and I'll make sure we add the or after the and in the first box.

**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, just to continue through the workflow, the data output is then stored in the EHR, which comes out of the first set, as we continue down the workflow, it says during incorporation of the CCDA, clinical information reconciliation is performed between the med, med allergy and problem list, and I'll add the or there too ...

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

Okay. And is it called, help me remember Scott, and I should remember but I just don't, is it called clinical information reconciliation in the measure?

**Scott Purnell-Saunders – Office of the National Coordinator**

Yes.

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

Okay. For some reason I don't remember that terminology. Okay.

**Scott Purnell-Saunders – Office of the National Coordinator**

Yeah it is, it's the – because it's a separate procedure it is done that way...

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

So it's done – is that in the transfer summary document stuff?

**Scott Purnell-Saunders – Office of the National Coordinator**

Yes.

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

All right, that's why ...

**Scott Purnell-Saunders – Office of the National Coordinator**

Yeah, transitions of care.

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

Yup, okay. I mean it makes sense, I just don't recall the language.

**Scott Purnell-Saunders – Office of the National Coordinator**

No, I understand. Then the EHR data and the CCDA data are then incorporated at that point with the clinical information reconciliation. The reconciled data is put back into the physician's HER. And then at the bottom, when you look at Start B, you're looking at if a patient's referred to a provider upon discharge from hospital or directly admitted to a hospital from a different provider, the transition of care happens at that particular point and the transitions of care is then sent up into step 2 where it happens in the clinical info reconciliation step.

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

Scott, this is John Derr and this is, Liz and the rest will recognize my windmill. But is a dead output stored in the physician's EMR and the hospital's EMR rather than EHR?

**Scott Purnell-Saunders – Office of the National Coordinator**

I mean it can be, we just use the term EHR to indicate electronic health record.

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

Okay.

**Scott Purnell-Saunders – Office of the National Coordinator**

Do you think – I mean, it's ...

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

Well in your guy's definition, the EMR is what's in the facility itself ...

**Scott Purnell-Saunders – Office of the National Coordinator**

Right.

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

... or in the doctor's office and the EHR is your transition of care record. And I know everyone uses them interchangeably, but it confuses some people because they don't then develop an EMR within their facility. But, the hospitals and you guys use them interchangeably, I just, it's just a long-term post-acute care problem.

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

I also was going to ask a similar question, but a little different which was, does the measure call for incorporation into the receiving EHR or does the measure call for availability of the information. The reason I say that to you it is a pretty significant difference. What I thought we had agreed to at this point was that a physician did not have to incorporate it into their EHR, for one thing, we don't even measure that on the hospital side, but that they can view the information through an HIE. So, is this an EP requirement that they be able to take the information and incorporate into an EHR, Scott?

**Scott Purnell-Saunders – Office of the National Coordinator**

I mean it is at this point, but I think we were, in describing the scenario, we're just trying to get what would cover most, what kind of happens in most settings, not necessarily all. So, I guess if the concern here is that this scenario is more restrictive than what is actually required by rule or criterion, we can change it, but we were just trying to make it generic enough to cover both, if we could.

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

Yeah, I'm just thinking about the testing procedure itself. So what I'm trying to think about, and this is where I'd have to look at the unit test. Is it required of our vendors, and of course, it depends on what they're actually testing for certification for. So if John Travis were on the phone and he was just describing what they would do their inpatient record for, they would not certify on this part. Now the question would be, if they were trying to certify their ambulatory software, would they have to do this or not? If they have to do it, then it's fine and we – because if it's a scenario, you could leave a part out, but you need to be sure, please, that the EP requirement is that they be able to incorporate it into an EHR.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

Because that's diff ...

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

This is Anne. Are you – what does incorporate mean? Does it mean store or does it mean view?

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

Well, it says display, so assumed incorporate meant store.

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

Well...

**Scott Purnell-Saunders – Office of the National Coordinator**

And the way that we're using it means both.

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

Because right now it says receive, display which I guess display/view and then when I read incorporated, I made the leap that we meant was actually stored inside their EHR, but you're right Anne – I mean, I don't know. Is there a better word, because if it really just means is available for use during the care of the patient, it doesn't have to be a permanent part of the EHR.

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

Can you say displayed or incorporated or and/or ...

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

How can you display something without it being in the EHR.

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

Well because if you don't have to store it in your database, you can...

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

Oh.

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

... just display it on the screen.

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

Exactly, you could be pulling it from the HIE, you could be pulling it from other places.

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

Yeah, originally from other places, okay.

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

Exactly.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay, we'll get that changed. I mean in our case, we use the term stored to be, to mean making itself available for use in whatever way that was required, but I do understand the nuance there is ...

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

It's a bad word for that, yeah.

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

And I just have one little question. That arrow going up from that during transition of care a referral summary CCDA is received, displayed and incorporated, and/or incorporated or whatever we're going to change it to, is the arrow supposed to go up or is it supposed to go down?

**Scott Purnell-Saunders – Office of the National Coordinator**

That arrow is supposed to go up.

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

And why would it go up, what's the workflow we're talking about?

**Scott Purnell-Saunders – Office of the National Coordinator**

So it's basically – it's combining the med list, med allergy and problem list that happened in Steps 1(a) through 1(c) with the transition of care that happened in 1(d), to all be reconciled in clinical info req in Step 2.

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

That wouldn't happen. I don't get that, I'm sorry. I would say if you're talking about doing the transition of care, the arrow goes the other way.

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

It goes to the transition, right.

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

Right. You've performed reconciliation and then you send the referral document during the transition of care, it's not the other way around. Think about that.

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

Because we – yeah, because a nursing home would receive it then after that or somebody else.

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

Right.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

And that white box is blacking out that arrow there; I guess the arrow goes over to the left.

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

You know, worse case it could be a double arrow.

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

Yeah, I thought about that. I mean we're just trying to think in terms of actual step order, and maybe that's the wrong way to think about it Scott, but when you think about it in step order, the step order was you would do the med reconciliation and then, like you said, you would send it to the doctor. Now Anne's right, it could be the doctor's sending it to us. I mean, I'm just using the, the EH perspective and that way the arrow could go both ways.

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

Right.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay. I mean we can add the other arrow there, I was just trying to make sure that it made sense, and I'll warn you, this same process continues over the next few slides, so we're going to have to make probably some of the same changes to the next couple of slides, as we explain it.

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

Okay.

**Scott Purnell-Saunders – Office of the National Coordinator**

Once everything happens in the clinical information reconciliation step, the reconciled data is then sent to the physician's or hospital's HER ...

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

Yup.

**Scott Purnell-Saunders – Office of the National Coordinator**

... and then that process stops. Next slide. So this basically shows what was just explained from a workflow standpoint into actually how all the various test procedures are connected. So you would start with, on the far left-hand side with 1(a), the medication list, going – and information being sent down to the clinical information reconciliation step, same with 1(b) and then 1(c). The data's sent to that and then the reconciled list, med list, med allergy list and problem list are then sent back. And then if you look at Step 1(d), where the CCDAs are sent, same thing would go up, the med list in CCDAs format, problem list in CCDAs format and med allergy list in CCDAs format is sent up to the clinical information reconciliation step. Then all that information's combined with the med list, med allergy and problem list and then sent out for the various outputs.

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

I think you're right about the arrows. The other thing Scott is, just a suggestion and this is one for consideration by the group, by using a triangle instead of a circle here, which may be the appropriate symbol for tests, I'm not, I've never seen it used that way, but regardless, it makes your eye move up like it's an arrow, not a ...

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

Makes it like – yeah, looks like an arrow.

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

It would be better if it was a circle or a square, unless ... because I'm just ... it looks like it's an arrow.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

I know you intend for it to be a triangle ...

**Scott Purnell-Saunders – Office of the National Coordinator**

Right, we do.

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

And then on the bottom of it, is this what we were talking about where two – 1(d) and 2?

**Scott Purnell-Saunders – Office of the National Coordinator**

Correct. So, basically explaining that test 1(a) through (d) can be done in any order, and then the clinical info reconciliation test, interoperability between all four.

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

Yeah, I'm okay with that.

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

And group, just a second input. If we had a nursing as part of the thing, that would be a box sort of off to the right or left at the bottom with an arrow into that CCDA, right?

**Scott Purnell-Saunders – Office of the National Coordinator**

Yes.

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

That could work. Yeah, okay. Can I change some of these when I make speeches, which I have to do next month.

**Scott Purnell-Saunders – Office of the National Coordinator**

Yeah, you can. I mean that essentially if you go back to slide 13, that's what we tried to indicate there.

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

Yup.

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

I – this is Anne – I think the arrow just going up on the bottom one on this is appropriate because the...it doesn't have the EHR as an output of that box. Does that make sense?

**Scott Purnell-Saunders – Office of the National Coordinator**

Say that one more time for me.

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

Okay. On the prior picture, when we put the arrow up and down...

**Scott Purnell-Saunders – Office of the National Coordinator**

Uh huh.

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

... it's because the implication that somebody is looking at that data on that bottom row ...

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

Right.

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

But on the next page, on the one we're looking at, you have that all consol – you don't have the view of this rendered anywhere in this picture. So it's just a feed. I'm just reconciling why I wouldn't suggest a two-way arrow on this one.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

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

Yeah, I went to the same thing and came up to the same conclusion.

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

Okay.

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

The other is workflow, this is more about saying have I reconciled everything...

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**  
Right.

**Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President, Applied Clinical Informatics**  
...in a singular place.

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**  
Right.

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

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**  
Okay.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay, I understand that. So we'll look at trying to determine a better shape that works to not make these look like arrows as much.

**Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President, Applied Clinical Informatics**  
Yeah, please. Okay, you want to keep going.

**Scott Purnell-Saunders – Office of the National Coordinator**

Sure. Next slide. So this goes back to explain with the various settings, your ambulatory setting and inpatient setting, how the EHR interoperability test scenario procedure would work. So starting with Steps 1(a) through 1(c), basically explaining what we talked through in slide 13, but walking it through in a bit better...a bit more detail.

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

So the only obvious one and I'm just going to say it out loud so we did, is the and/or, because you might not change something, you might record or you might access, but you may not change.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay. Okay. Next slide. This just goes back and explains the summary of where we are, what we've gone through, what the purpose of the scenarios is – test scenario procedures are, what the unit-based testing currently is and what the scenario-based testing is. We'll add a little more detail based on what we add for slide 6, with the combination of 6 and 7 or 6 and 8 to reflect that. What this slide was just basically used to show, kind of wrap things up and to bring people back to what we've been through through the slides presentations. And then slide 17 is just a glossary for information or terms that folks haven't – may not be as familiar with, to give a better definition of those in more detail.

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

Okay. Let's talk about, at least for me, can we talk about the glossary for just a second.

**Scott Purnell-Saunders – Office of the National Coordinator**

Sure.

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

So, on scenario-based testing you have this use of test scenarios to evaluate the conformance to certification criterion or criteria. That's not how I think about this. I thought the scenario-based testing was to base it based on a clinically relevant scenario.

**Scott Purnell-Saunders – Office of the National Coordinator**

It is, but it still has to conform to these certification criterion.

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

But at least, I mean, what's the difference between that one and when you say test scenarios versus unit test? I...please others speak up if I'm just being picky, that's fine. But to me ...

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

Well, would CCHIT use the scenario test, I mean, they use it to get an idea, but then they have their own testing. It's not the same thing, right?

**Scott Purnell-Saunders – Office of the National Coordinator**

I mean, I'm not going to say unfortunately, but the test labs are currently, are currently linking tests together in an order and format that makes sense to them and they have been, as we've been told since early parts of testing, because it makes...it adds more efficiencies for them. The goal with our development of the scenario-based testing was to figure out a way that could be standardized across all the test labs. So, I do...I mean, I'm not opposed to adding any additional terminology here that would make it more clear, I just kind of want to get an idea of exactly what that would be.

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

A test scenario is, in essence is really workflow, right? Isn't it?

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

Yeah, I mean, that's what it says – that's what's interesting. Under test scenario it says that, "broad term used to describe the linking of unit tests to represent a clinically relevant workflow. That's perfect. But, clinical based testing says use of test scenarios to evaluate the conformance. I thought that...what that was...it's just me. I just thought that clinic – scenario-based – I mean again, I may be – I'm sorry guys, it may be words, but it doesn't – I'm losing my words, because I'm having difficulty making – into meeting scenario-based testing.

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

It's hard to have a clinically relevant workflow when it's only a test scenario.

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

Right.

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

So, it think what you're saying Liz, and I tend to agree, is that the clinically relevant workflow, those three words should appear in the scenario-based testing ...

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

Well could we combine scenario-based testing and test scenario? Why is it ...

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

Yeah.

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

... why do they need to be separated? Scott?

**Scott Purnell-Saunders – Office of the National Coordinator**

The scenario tes – the test scenario in general was what we always called the overview of everything. So this is a test scenario, it shows the linking of tests, but it doesn't actually get into like the particular certification tests. So the unit test and how they would interoperate and connect to each other. So the scenario-based testing was saying, how will we combine these three or four different unit tests together, which is why the separation of the definition. It's just basically taking another step further in more detail.

**John Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**  
Scenario-based testing is the title of a book and the test scenarios are chapters.

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

**Scott Purnell-Saunders – Office of the National Coordinator**  
Is the consensus that it's ...

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**  
I mean, there's an abuse of the term test scenario in this list.

**Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President, Applied Clinical Informatics**  
That's an understatement.

**Scott Purnell-Saunders – Office of the National Coordinator**  
Okay.

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**  
So for if we're picking on these two, we have to pick on the rest.

**Scott Purnell-Saunders – Office of the National Coordinator**  
That's fine.

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**  
What if we said ...

**Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President, Applied Clinical Informatics**  
It is Monday morning, we know guys.

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

**Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President, Applied Clinical Informatics**  
It is. Okay, what if we said use of clinically based test scenarios to evaluate, blah, blah, blah.

**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**  
Okay. Great.

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**  
Yeah.

**Christopher Ross – Mayo Clinic – Chief Information Officer**  
As long as we use that phrase elsewhere, I just – I hear what you're saying and I think if you – wouldn't want to kind of put too many variations of clinically-based scenario test, scenario testing, test scenarios because you begin to say, now ... different

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**  
We already went there.

**John Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**  
Yeah, you're in a car, right, so you're getting all these words without seeing a slide, right?

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Well you know, I looked at it this morning and it's surprising how much you can follow along, but that has been my issue all along, has been if there's a specific term of art, we shouldn't be casual about it. And so it feels like we ought to use the phrase scenario test kind of in one formulation unless we really do mean more than one thing.

**Scott Purnell-Saunders – Office of the National Coordinator**

Okay.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

And that unit test ought to mean just one thing, the atomistic individual test, which is, aligns with the actual requirement of the regulation.

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

So, have you had just about all the input you can take Scott?

**Scott Purnell-Saunders – Office of the National Coordinator**

Probably not, I can take a little bit more. We've got about fourteen minutes, but I know you guys have got a little bit else to cover, so we'll stop here, I'll make some revisions and we'll try to get this out as soon as we can.

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

Great. So, MacKenzie, did you send out – yeah, at 8:23 ...

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

Yup it was, it got built into the webinar and at 9:23 Eastern Time it went out to the group.

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

Okay. So ...

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

And I got it, so ...

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

So, I think what Cris and I wanted to, for the – was there, is there anybody in the workgroup that did not attend the Standards meeting either virtually or in person last week?

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

Sounds like we have all people who are on the Standards Committee and not the other people in the workgroup.

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

Yeah. So Cris, what do you think about – I think we can certainly talk about – I think you guys got the gist of it that Cris and I were successful in sort of advocating our position that there are a number of these things that we think the Implementation Workgroup could have extraordinarily valuable input into, looking at the viability of the proposed standard in a real-life scenario and so on. I'm thinking Cris, and then I want to hear from you, that we may want to wait to have this discussion until the week after next, because we're not meeting next week because of HIMS, with hopefully a larger group to talk about where we go from here. And MacKenzie, we may want to send out a little notice to the workgroup to remind them that we're going to be talking about the 2013 work plan. So hopefully we'll get everybody back on board next, in two weeks.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Yeah, that makes total sense, given that we've got sort of a small caucus. I just – there were a couple of workgroups that were left out on the work plan that Doug Fridsma distributed; the Implementation Workgroup was one, Patient Engagement Workgroup was another, and so on. And I think the main point that at least Liz and I were sitting close enough to each other we could have a little sidebar and Anne, I think you were on the phone, am I remembering that right?

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

Yeah Anne was on the phone and John was there.

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

Yeah, I was on the phone.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

And John was across the table...I guess the main thing was just an under...overriding concern about we can develop absolutely beautiful standards and we can continue to propagate them and make them more complex and make them deeper and richer and it isn't going to mean squat if the industry can't absorb it. And that's been a big focus for our workgroup. I think we want to make sure that we express whatever view is appropriate from this workgroup to our Chair and Vice-Chair and the rest of the Committee and so on. So that was a big piece, but the other little thing Liz, that we may want to do is at some point figure out when do we want to bring to this group the discussion we've been having about hearing...

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

Yeah...

**Christopher Ross – Mayo Clinic – Chief Information Officer**

...and what do we do around that.

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

Boy, talk about being in sync, I was just thinking the very same thing. So, I think we need to bring it in two weeks. MacKenzie has provided us with a format – template to get back to ONC and tell them what and why and with whom do we want to do a hearing. And Cris and I have not finished that, it's sort of been developing in our heads and through our conversations, and so I think what we owe the workgroup and then MacKenzie then back in a more formal way to you, is sort of what are we thinking. And we thought – what Cris and I talked about is we saw this work plan and began to talk about this would be the perfect opportunity to tie it all together. The other thing that we haven't had a chance to talk about, but I had an opportunity to meet with the Meaningful Use and Certification and Adoption group out of the policy area. And I'm wondering too Cris at some point if we want to do like we did before, which was join together with the Certification and Adoption Group for the hearing. But we can talk ...

**Christopher Ross – Mayo Clinic – Chief Information Officer**

That sound's great ...

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

... about that more as we go forward.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Yeah, that sounds great, we hadn't had a chance to talk about that. I think just one other piece we may want to share at this point for our colleagues, just as a preview. A lot of the conversation we've had, Liz and I, has been around looking at a combination of Stage 2 and Stage 3 kind of components for the hearing ahead, because I think you all are hearing, we certainly heard it in public comment at the end of the last session, there's still a fair amount of concern that we didn't sufficiently learn the lessons from Stage 1 and that the industry is struggling and we ought to do a pulse check around that. So, we thought that some of the materials that were in the work plan, in some ways, laid out some interesting topics for hearings.

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

This is Anne, can I just add a little thought or plant a seed.

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

Of course.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Please.

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

Okay. Major reason why we're all even on this phone is to get things digitized so that we can measure things so that we can bend the cost curve down, just because of the intelligence that we can gather. I don't see a lot of connection to that. I think there's an assumption that just because we're doing what we're doing that all that will happen, and I don't know that to be the case. Is there any plan to look ahead to what the real goal is? I get making people healthier and happier, but there's the cheaper is in there.

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

Yeah, you're right. So I think – that's a very good point. I think as we, as a group as we take forward the what and the why and so on in the presentation to the ONC for approval for a hearing, we should keep that in mind, it's a very valid point.

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

Yeah, I'm just having a hard time seeing the end game. And I know what expectation is out there, because I'm a payer and I'm ...

**Christopher Ross – Mayo Clinic – Chief Information Officer**

I was going to say, leave it to the payer to raise these uncomfortable issues.

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

I hate to say it, but I'm ...

**Christopher Ross – Mayo Clinic – Chief Information Officer**

No, you're right, you're totally right Anne. You're totally right.

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

I admit it's ... budget, they're changing focus to quality and I don't know that we're not going to spend a trillion dollars and not get what we're looking for.

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

Yup. So I think what we'll do is, keeping that sort of really clear purview on this entire process in mind, as we plan the hearing submission, then we will – I think that it's a good point and it should be brought back to light.

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

There is a goal.

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

There is a goal.

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Yeah, there is a certain risk that we've all become kind of insiders on this. Anne, your comment is just fantastic that you get caught up in the sort of details and drama of how difficult some of this stuff is to push forward. And it's sometimes easy to lose track of why the heck did we start on this journey at all. So thanks for raising that.

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

Right. Okay, great.

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

Well this is, as always, a terrific meeting. MacKenzie, shall we go and pick up public comments please, before we sign off?

**Public Comment**

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

Sure, 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. No comment at this time.

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

Right, thank you. Well thanks guys, as always, it's a charged up group and great work and Scott, thank you for all of your patience with us. I think at the end of the day, the work product will be really, really a good product.

**Scott Purnell-Saunders – Office of the National Coordinator**

Not a problem, thank you guys for your help, as always.

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

Absolutely. Cris?

**Christopher Ross – Mayo Clinic – Chief Information Officer**

Thanks all. No, that's it, great call.

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

All right. Happy Monday everybody.