

**HIT Standards Committee  
Implementation Workgroup  
Transcript  
November 12, 2013**

**Presentation**

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

Good afternoon this is Scott Purnell-Saunders from ONC and this is a meeting of the Health IT Standards Committee Implementation Workgroup call. This is a public call and there will be time for public comment at the end of the call. Please remember to state your name before speaking as this meeting is being transcribed and recorded. I will now take roll. Elizabeth Johnson?

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

Here.

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

Cris Johnson, sorry Cris Ross?

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

I'm here.

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

Anne Castro?

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

I'm here.

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

John Derr? Timothy Gutshall? Joe Heyman? David Kates? Tim Morris? Stephen Palmer? Sudha Puvvadi? Wes Rishel?

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

Here.

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

Ken Tarkoff? John Travis? Micky Tripathi? Gary Wietecha? Rob Anthony? Kevin Brady? Tim Cromwell or Nancy Orvis? Any ONC staff on the line? Well, I have Carol Bean, Seon Davis and Carmelita Marshall with me.

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

Great why don't we – we do have a – and I don't know if it's your speaker or not Scott.

**Caitlin Collins – Project Coordinator – Altarum Institute**

Well, I think if everyone on the phone could please either, if you're logged into the web, please either turn down or turn off your computer speakers that should help prevent the echo. Thanks.

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

Okay, great, thank you Caitlin. Cris and I think – and Cris we'll get comments from you in just a moment. I believe what we're going to spend the next hour or so doing is really getting a much clearer understanding of the clinical scenarios used for testing, their development and so on.

As many of you recall at the last Standards meeting we had a brief discussion about the clinical scenarios and where they were and there were several questions and I believe that Carol and Scott are ready to talk and answer those questions today and that is the purpose of this meeting. Cris, did you want to add anything to that?

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

I don't, today is I think largely oriented around us getting up to speed with what the work has been around those scenarios, looking forward to it.

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

Great, Scott, you want to or Carol whomever, will you please go forward then?

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

Yes, Ma'am, next slide, please. This is just a content slide explaining what we will go through today. We'll first talk about the development to kind of reiterate some of those steps, go over the overall workflow review, which we've done, then start to talk about the workflow in specific detail, the description, the assumptions and then we'll talk through all the group 1 scenarios which were previously explained starting with the encounter intake workflow, the interoperability intake, the care ordering, care results, post care workflow and finally the encounter intake.

And we'll touch on the group 2 scenarios and what our next steps are going to be moving forward with additional planning and events for early 2014. Next slide and can you guys hear me okay?

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

I can.

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

Okay, great.

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

Yes, it's really good, thank you.

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

Beautiful. This slide goes into the development that we've covered thus far with the development of the testing scenarios. We'll show for example the script development started in 2012 where we kind of got a high level overview of where things would be and really talked about them in, you know, more of a narrative format.

In early 2013 we developed our proof of concept, developed our first draft of testing scenarios and conducted our first pilot. Towards the end of 2013 we finished the actual release of our draft testing scenarios and published them on our website. Part of this call is to provide a little more detail in order to give this group and opportunity to provide us feedback through our normal, you know, feedback channels.

So, once we've ended with the call certainly reach out to me directly and shoot me an e-mail at [scott.purnellsaunders@hhs.gov](mailto:scott.purnellsaunders@hhs.gov) with any feedback that you have on the approach we're covering currently in our draft testing scenarios and any suggestions or feedback moving forward and we'll do our best to try to incorporate those as we make some refinements and go through our next steps.

Once the draft testing scenarios are completed and been reviewed and updated as necessary they'll be approved for use in our testing program. We're hoping that happens in early 2014 and they're available for use as such then early to mid 2014, which is indicated by that green star and then group 2 development is starting in early 2014 that timeline is yet to be determined as it will really rely upon what we're able to currently get done in our current testing program and how the implementation of rollout of this first group of testing scenarios goes. Any questions here? Great, next slide.

So, our goal with this and to look at the workflow was to basically take what we learned in the pilot and to develop a broader scope for the developed testing scenarios. We developed a workflow that followed a patient from the initial contact in the provider's office through their care and follow-up and to also work through following the provider or hospital through their public health and clinical quality measure reporting.

At this point in time the workflow was designed to outline what criteria should be met by scenario with the pilot scenario are included in this workflow and also to get additional feedback from clinical experts such as yourselves in this call at this particular time period.

As indicated on the last slide we are seeking your feedback on the concept, structure and usability of the Workgroup, excuse of the scenarios and we'll look to integrate that feedback as we move forward with the published drafts that are available on our website. Next slide.

This slide should be familiar we've covered it before and it just goes into detail with respect to what specific certification criteria are covered in each scenario. Group 1 is indicated by the blue box at the top, group 2 by the orange box at the bottom.

As we talked about, the group 1 development occurred between July 2013 and will complete in February 2014 with the group 2 development to be developed in 2014 moving forward. We'll go into more detail surrounding where the criteria are aligned in each particular scenario as we move forward through the rest of the presentation. I'll pause for any questions here. Next slide.

So, our goal with this was to develop a clinically plausible workflow. The workflow was intended to represent one way to go through all the particular certification criteria but not the only way. As Carol and I have indicated on previous calls the goal with this first set of – first group of draft testing scenarios and then group 2 to come is to start at a starting point so that we can develop a larger library to come, it's not the only way that you could go through a clinical scenario it just represents one way that we felt would work best to fit across all the developed criteria.

Certainly, we're not trying to imply how things are used or any particular development surrounding usability. The goal is to facilitate the connection between individual testing – individual certification criteria in a workflow that kind of makes sense in the various clinical settings that we see. Any questions here?

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

Can you tell us what slide you're on Scott? I can't be on the WebEx right now. Can you tell me where you are please?

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

We're just completing slide 6.

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

Thank you.

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

Not a problem. And on slide 7 we're back to the overall workflow descriptions. Great, so now we'll go through the workflow labels and to describe where – you know, to begin the description of where they actually came from.

So scenario one is the encounter intake, scenario two encounter interoperability intake, scenario three encounter care ordering, scenario four encounter care results and scenario five encounter post care. These scenarios, like we said initially, represent activities that are largely pointed towards the clinical end of the spectrum and could be performed by a care team or a patient.

Group 2 represents activities that are largely more administrative and also are going to cover things that are done by administrative uses as well and those are represented by scenario 6 reporting, scenario 7 privacy and security, and scenario 8 system. I'll pause for any questions here.

Great, moving onto slide 8 the title here is the overall workflow assumptions. The criteria that we've designed these scenarios to fit that the testing will proceed sequentially through each. We worked through the various options for removing certain tests and substituting some and there are some scenarios that are going to lend more towards that substitution or omission being more fluid than others and we will also – the scenarios are designed to include additional feedback when pieces of the developed scenarios are skipped to ensure that that workflow can continue on the prescribed path.

The workflow is also a core of each testing scenario, it's not going to include all the nuances to each one but it tries to encompass the basis for where each certification criteria was based and to provide as much detail as it can moving toward each one.

Moving onto slide 9 this basically gives an overview of what each the 5 drafted scenarios were meant to accomplish. So an encounter intake, which is scenario one, actions which could be performed by any care member before a patient sees a provider, during the interoperability intake actions which could be incorporated into a care summary document received from another hospital or provider before treating the patient. The care ordering basically when care occurs or actions related to order and care for the patient medications, lab, imaging or any other options during the care episode.

The care results, actions related to results of care from the patient and orders from the patient that would occur either ordered by the provider or the patient and post care, actions that happen actually post the care a particular event has occurred that can include developing creation of summary of care records or any other follow-up ordering as necessary. I'll pause here.

Great, moving onto slide 10, so, now we look into more detail for each of the developed scenarios. I'll pause for a second. This layout is what we'll follow for the next 5 slides to describe in detail what is covered in each particular developed testing scenario. So, we'll start here in the center where we talk about the workflow.

So, the patient arrives for a visit with the provider in an ambulatory setting or hospital in the inpatient setting and the following information about the patient is recorded in the provider or hospital's electronic health record product. So, you have your demographics recording, medications, medication allergies, problems, immunization information, smoking status, family health history and in the inpatient only setting the advance care directives and in the ambulatory only the cancer disease information, and then vital signs, BMI and growth charts. This is reflective as to what exactly would appear in the developed certification criteria which capture that initial information.

When had this discussion or had a discussion about this particular workflow before we showed the particular testing scenario, certification criteria, excuse me, that referenced all of these where you're capturing the demographics and your medication allergies and your problem list, this scenario basically combines all of that into one particular bundle so that all that can be done at one time.

And because it is done at a single point in time it doesn't have to be reworked during the rest of the testing scenarios which lends more into the type of time savings and input savings that we would get from doing a developed testing scenario process. And at the bottom you'll see the tests that are listed there, I won't read them for you guys, but, you know, starting with demographics and then ending with cancer care information. I'll pause here for any questions.

Great, moving onto slide 11, so the encounter interoperability intake workflow, in this particular workflow a provider or hospital receives the transitions of care referral summary for the patient from a recent hospital or an inpatient visit from an ambulatory setting.

Transitions of care referral summary for the patient is received, displayed and incorporated into the EMR or EHR in the particular location and a clinical information reconciliation is done between the medication, medication allergy and problem list that were stored in the EHR, which were captured during the first scenario. I'll pause here for any questions.

And this is also the scenario for which we did our pilots this spring. We've covered this one in a fair amount of detail as well and we got good feedback on the way that was designed and developed, you know, which helped to, you know, further this process along. Next slide.

Now we're onto slide 12, so this is the encounter care ordering workflow, we'll describe it during a visit in an ambulatory and admission for an inpatient setting the following orders are recorded for the patient medication, lab and then radiology or any particular imaging orders.

The EHR indicated drug-drug, drug-allergy or contraindication, intervention. The provider or member of the care team then writes prescriptions for electronic transmission and checks whether a drug formulary exists for the patient and given medication. In inpatient, only a member of the care team administers the medication and documents the medication administration in the patient's record in the hospital's EHR.

So, as you'll see below the various tests that are, you know, instituted here, the CPOE or the computerized provider order entry, drug-drug or drug-allergy interaction checks, ePrescribing, the drug formulary checks and then the electronic medication administration record or eMAR. Any questions here?

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

I don't know about anybody else I'm just trying to envision how this actually works. I mean, I'm trying to let you get through the presentation and maybe others are and then we can ask questions.

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

Okay.

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

Okay.

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

Next slide. Now we're into the care results workflow. So, during a subsequent visit for an ambulatory or a hospital inpatient admission the following occurs, EHR indicates that image results for the patient are available and they're accessed through the EHR software, clinical lab results and test values for the patient are received and accessed in that same software as well.

The EHR electronically identifies diagnostic and therapeutic reference information for the provider and education resources for the patient. The eNotes of the patient visit on admission are recorded in the EHR in the ambulatory setting only and a clinical summary for the patient is created from that particular set of information as described earlier.

So, the tests involved here were the image results, incorporating the lab tests, the values and results, the clinical decision support, the patient specific education resources and electronic notes, and then the clinical summary which actually got cut off in the PDF conversion, so, we're sorry, that's where the CLIN is on the right-hand side, I do apologize for that. And so I'll pause for a second.

Liz, we do understand that, you know, we're trying to describe kind of how this works, the published draft testing scenarios kind of go into more detail on how this would actually be done, this presentation was really...and we're trying to get through it as quickly as we can so we open the floor for questions to explain kind of how the process would work.

We did get a fair amount of feedback during our pilots that were conducted in the spring and summer kind of about the best way to get this done and we've been – you know, we've refined our process based on that.

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

So, I think, you know, potentially this Workgroup feels completely out of the loop because we're not seeing the feedback, we don't know what the pilots – I mean, it's very difficult to help or to add our expertise without information other than slides that say what you're going to test.

So, I'm not sure what we can do to help you other than it's gone very far away from where we were when we started this and we had worked diligently on diagrams to talk about flow and how it would be done, that's about as much help as I can add. I don't know if Wes, Carol, you know, Cris, somebody else want to –

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

Well, I guess, yeah, this is Cris, so I guess my question is somewhat related, thanks for this overview, I guess I've got two sort of pieces one of which was maybe you could help illuminate for us why these particular scenarios were created relative to any other. I'm sure there is a relatively straightforward answer for how these got prioritized.

I guess the other question would be what do you see as the process for getting clinically relevant input, I think that's what we spent the majority of our time on earlier in the spring and into the summer. So, that's question two, how do we get clinical input?

And number three, would be, you know, what feedback have we been getting on previous scenarios and are we using that feedback to improve our process that we could bake into this?

So, I understand we went through a hiatus of a shutdown and a number of other kinds of things, but I'm with Liz a little bit, well I'm with Liz completely, I'm just not sure of the full context for this and how we can be most useful.

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

Okay, so I'll address the third question first. Certainly, because of the – I mean, I'm not going to blame everything on the shutdown at this point, but to date we haven't received much feedback at all on developed and published scenarios as is. We had these completed in late September as we had targeted and communicated in the Implementation Workgroup call in August and again in the Standards call in August as well. So, we reached that target but to date didn't receive anything from the public and/or, you know, this Workgroup on feedback with the published and developed versions that were completed.

So, part of the reason why we approached this presentation from the perspective that we did was to try to provide the overview and to give as much background as we could and as much, you know, overall detail as we could to get that feedback to try to encourage those that are on the call to take, you know, take some time and look at the published scenarios that are up and available on our website and then submit the feedback to us through our standard feedback channels.

Certainly, if the, you know, Implementation Workgroup as a whole has overall feedback that they want to support, you know, that can come through the standard channels that the Workgroup would support and that would, you know, mean developing a memo which would go to the Standards Committee and come through those formalized channels or individuals from the Workgroup can also submit information to us through our direct channels meaning submitting an e-mail to myself, you know, Seon or Carol and we will certainly receive that and use that as we're refining these drafts before publication and integration into our overall testing and certification program.

Certainly this, the presentation was developed, you know, prior to shutdown so it was kind of the natural progression from where we were previously we received information and feedback that was just simply showing the diagram and trying to talk through the narrative without the overall understanding of where, you know, some of the background information came from and how this all would connect wasn't as useful. So, we were trying to kind of take that a step further with the feedback that we received.

And to answer the first question we picked these five because they were – we had the bucket somehow, we didn't have enough time to get, you know, the entire set of certification criteria developed into testing scenarios at once and the way that we looked at it was to focus on an encounter, which is something that we had done consistently from the original development starting in 2012 was to look at, you know, a particular encounter with a patient at a provider whether it be a hospital or an ambulatory setting to get, you know, some sort of care and how was the best way to accomplish all of that and then split the scenarios out into, you know, digestible pieces as opposed to one big, you know, one big chunk that people wouldn't be able to get through at one time.

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

So, Scott this –

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

This is Wes –

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

Wes, can I just follow-up really briefly for just a minute?

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

No, no you go ahead that's fine, I just wanted to get in.

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

So, I'm sorry, yeah – so, I think my third question around feedback I didn't frame very well. I'm curious about feedback from the industry, feedback from attestation groups, did they like the scenarios, did they work, did they not work that sort of thing and then if you can go back to how can we – what do you see as the process for clinical input that would be helpful.

**Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology**

Hi, I'm moving – this is Carol, I'm moving a little closer to this, mostly I'm going to kind of try to restate some of what Scott said because I think the answers to your questions are in there, but would like to kind of maybe take it at a different picture.

So, what we tried to do was to take all of the 2014 requirements, which are right now unit tested, you know, each one is tested separately and we, you know, put them in buckets, we tried to come up with some buckets and we came up with two big ones and because of the emphasis on the clinical setting and the clinical workflow that was sort of the natural divide of the two buckets was the sort of what would happen in the clinical side of the entire enterprise kind of thing with respect to, again, remembering that we're looking at the criteria for 2014 certification.

So, we looked at those criteria and we kind of separated them into two big buckets one was more clinically related and the other was more administratively related and those are the blue bucket and the orange bucket as we kind of showed them.

And we developed, because of the interest, that we heard from this group and others, we focused on the first set, the blue set, the clinical set first and so what we have presented in several different ways over the past 6 months is how we organized the criteria and the individual tests to be able to make a logical plausible, you know, possible workflow that would be potentially used.

You hear a lot of these little words because this is to say that this is not the only, it is one that makes sense given the criteria that we have, that we could use to have a start and dump in some data and use the data flowing through multiple tests, test procedures that would be connected by the sort of clinical logic, small "c" small "l" and that would go from one test procedure to the next test procedure in a relatively seamless fashion from the perspective of, you know, a provider that was watching or the perspective of the industry that had created the product that was under tests, the system under test.

And so, we also needed to be able to pop things out if a product did not have it, you know, and wanted to do less or maybe even a little more but ways that we needed to be able to look under the hood to stop it at any point and look and assess so it wasn't a black box so that we have complete traceability back to each and every one of the criteria.

So, essentially, this is just a choice of some buckets and the feedback and the criteria that fit within those buckets, and the sequencing that allows a set of data to enter in, you know, one side of the bucket, you know, go down and be, you know, plucked out and looked at and then come out at the other end of the bucket having gone through anywhere in the example that's up right now it looks like six different criteria at one whack, you know, rather than having six different tests and all that that engages it would be six criteria tested in this one scenario.

Now, when we talked earlier and when we were going through these descriptions the second one we discussed which was the intake scenario was one that we did a pilot on late spring, I believe it was, with two vendors and a test lab.

And so what they did was they took that scenario and they worked with two vendors and their products and carried through, and this was a test under observation, an observed pilot study, where we watched them and we used – had chosen vendors who's products – chosen products for this pilot test who had already been certified to the criteria that were in that scenario and we listened to them, you know, with sort of a think out loud, talk out loud on both the part of the test lab and the vendor personnel that were engaged in that and that feedback, that was a very small pilot it was only one small scenario but it had some interoperability stuff and it was enough to – and we got the feedback from the two vendors and the one ALT as they went through this thing and it was, you know, very well received both the vendors and the test labs opined that they were very enthusiastic.

And they opined that this particular procedure, as it was demonstrated, already took a lot less time than the actual test for those criteria in the certification testing, but also this type of procedure, if applied to additional criteria would be expected to reduce test time for – if something is coming in to be tested to all of the criteria or complete product, that it would reduce the test time from approximately 3 days, start to finish, to perhaps a day and a half at max.

So, and it was also something that, you know, we kind of have our little focus on things and I was – something that I hadn't anticipated, but which was noted by the vendors that this worked much better, that this process worked much better in the development procedures, you know, in their processes and that they expected it to improve their – not just the testing itself but the preparation for testing and development, their development cycles and that was an unintended benefit but one which we're quite happy to take.

So, the how we chose it was pretty much a matter of convenience to be sure that we got everything covered and focusing on the clinical, and the feedback just described was from an actual pilot with vendor and test lab and what Scott was talking about, we had posted – if you look at what we have posted is something that looks a lot like the ONC approved test procedures only they're scenarios and they're – it's a step-by-step how do you go through, you know, how would a test lab use these scenarios in the testing situation.

And from the vendor perspective what is the vendor actually going to do? It's not the literal script that the test lab uses which they have scripts that get to the detail of okay take a screen shot, okay write down this number, okay – you know, so more very procedural kinds of things but this is also able to be consistent across all of the test labs and allow them to, you know, follow and to archive and record in the ways that they need to, but to have a consistency across all of the test labs as they go through these scenarios.

So, when Scott was saying we didn't get much feedback and that was the unfortunate part of the timing with the shutdown it was posted right before the shutdown and it was up, it's still up the actual procedural documents for these scenarios are on the website and we haven't received very much input from it.

So, that's what we would like to have from this group is the actual input from, you know, in looking at those in the same way that you would provide, and many of you have provided, input to the test procedures, the ONC approved test procedures that are used for unit testing is to take that same fine tooth comb and look at if we reorganize these in a way that makes them be scenarios and sort of in buckets and chunks does it still make sense or does it – you know, hopefully make more sense.

And, you know, what, from your perspective what would be, you know, some considerations that we would need to have that make it either more clinically plausible, more clinically relevant or on the flip side of that more helpful in tune with what the development and vendor process is.

So, like I said, you know, perhaps if we had had some of that input it wouldn't have surprised me that it worked so well with the vendor development cycle, you know, but, you know, I like nice surprises. So, I was quite happy with that, to have that surprise.

So, we would love to have your input on those, which as I said look a lot like and, you know, that's intentional, the test procedures that we already have up, but – and so it's however you would like to, you know, divide that up we had envisioned you might have groups, because there are 6 scenarios, you might have – what six, five, 5 scenarios that you may have little subgroups that really focus and talk about them, you know, however you would like to address it.

So, if you want to do it individually that's fine or if you want to do it in one big fat group that's fine too, but, you know, we are trying to get – before we roll this out, and what we've seen is if we just put the test procedures out, you know, over the past few years, you know, without trying to get input there is a lot that we haven't thought of that we can't be possibly aware of, you know, and so that's why we want input from people who have both the clinical expertise and experience as well as the development expertise and experience.

So, that's kind of a long-winded way of essentially repeating what Scott said, but, you know, with my plea of what it is that we're looking for from this group and, you know, something that, as we indicated at some point during the – I guess early on when we were talking about the timeframe, we're going to pilot these again or pilot all of them.

We had just piloted the first one and we did some updates and we fixed the descriptions, the narratives themselves, the procedural aspects to be more, you know, to be clearer, to be more explicit, etcetera, and so it looks like, you know, around the, you know, juncture at the beginning of the year that we're probably or not probably, but our timeline has us doing pilots with these things again with some vendors and test labs, vendors who have already certified on the particular criteria that are included in a given test scenario and the test labs, you know, that administer it. So, we have the test lab vendor pairing there.

Again, pilots under observation with our team and what we can do, if there is interest and if it works out, because this obviously is very proprietary kind of stuff when you're looking under the hood of a lot of these systems and we have to get, you know, special dispensation from the vendor and the test lab for us to observe this, but we may be able to have an opportunity where somebody is willing to have – and I think there's a good chance of this, where – in the January timeframe where we could invite some or all of the Workgroup to observe the pilots. But we want to get feedback on the procedures before we go to pilot again, because obviously there is –

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

Sure, sure.

**Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology**

Pilot, etcetera. So –

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

Okay, so –

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

So, Carol, thanks for –

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

Go ahead. Go ahead Cris.

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

Well, thanks for that thorough recap it's helpful. I really don't want to pursue it more right now interest of time, but I guess I'm interested in two data points one of which is beyond the pilot group of two EHRs and one scenario, and a credential group, you know, how did it go, how many people chose to use scenarios as opposed to test groups those sorts of things. We'll get that later.

And then the other piece is just what process are we going to use in this committee to get clinical input? Should we use the same process we used last spring and summer or something else? I think I'll just drop it for now in the interest of time, but it would be good to come back to that so we know what to do.

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

Wes here.

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

Yeah, I – yeah, go ahead Wes.

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

So, I think it's instructive to look back at slide 3 which is the schedule. If I understand the schedule, if I'm interpreting it correctly, after the proof of concept the full set of the scenarios for group 1 have been developed but no one has had the option to use them yet, in fact, if I understand this correctly, no one has really had the option to use any of the scenarios yet. Is that correct or the one that was piloted –

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

Correct, except for that one pilot, the pilot that we conducted this summer, but we are doing this –

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

Yeah, but after the pilot, after the pilot it was shut down again, that is in terms of our getting feedback in terms of what vendors have chosen scenarios versus what has chosen unit testing, they haven't yet had the opportunity to choose scenarios, if I understand it correctly.

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

Yes, we cannot institute them into the program to allow test labs and certification –

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

Yeah, okay.

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

Program until they're approved.

**Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology**

We're right –

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

So we have –

**Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology**

We're not going to approve them until we go through the pilot and get the input.

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

Yeah, yeah, no I think and that's a perfectly reasonable approach. Now, my next question is – I just lost the question. How many vendors are still – will benefit by these improved test procedures, by that I mean they still have to certify for the 2014 edition or they're likely to have to certify using these procedures in 2015 or 2016.

Do we have a sense of whether – I mean, is this an irrelevancy for most of the vendors because they've already been certified or according the timeframe here, which looks like the – somewhere in the second quarter of 2014 vendors might be able to choose the scenario-based testing. Are there enough of them left for this to be a significant choice if not we're going to have a hard time generating interest in reviewing the procedures. So, do we have any sense of that?

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

So, I mean, Wes, we've had this – some discussions surrounding this previously and our answer at this point even as we become – as you rapidly approach January 2, 2014 there is still a significant benefit to vendors in offering this as an option. Certainly, during the pilot phase that we conducted we heard from those that participated that this would benefit them. Certainly –

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

Hey, Scott, let me – because we are going to run out of time and I know Cris has to drop off and I'm catching a plane and Wes has got to get on a plane, while I understand that there is some benefit, I'm going to tell you bluntly because I think we will maybe get to the bottom of the pile faster that way, those who have already certified, you know, in talking with the major vendors I am not seeing the interest that you're eluding to in terms of recertifying because there is very little benefit to them.

It feels like, to me, that maybe at least we ought to consider is this – given the timeline that we now sit on shouldn't we be looking at this for Stage 3 instead of trying to – I mean, continue a circle around Stage 2? Regardless of how we may feel about our preparedness for Stage 2 and certainly the number of persons who have certified for Stage 2 has gone down dramatically, which is a concern and several of us are working on that concern on a different front, but, you know, I think the work that's being done and the concept that we were talking about a year and a half ago are very real.

I think what we're trying to say is, as, you know, politely as possible is our timing seems to be off and, you know, as a very interested participant I would tell you that I think the work would be better spent in preparing for 3 and please others comment, I mean, maybe I'm completely off, but I'm not seeing that a bunch of people are going to run up and start certifying under this process.

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

I'd like to comment on that if I can, is that okay?

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

Yes, absolutely.

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

So, I think if there are a – if we have reason to believe that even 10 or 20% of the vendors would have the option to certify under the scenarios then I would argue that getting that experience under our belt would leave us in a much better position for Stage 3.

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

So –

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

I think, you know, what we see in the scenarios is experience that came after doing testing using unit testing and that experience would help. I don't know the answer to that question.

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

Well, so Wes, I agree with you in terms of the concept but I'm questioning – I mean maybe we just put it out there and see what happens, but I'm questioning the willingness to do it. I agree with you –

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

Well, yeah, I mean –

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

Anything we can do to get experience would help us.

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

And I –

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

So –

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

Go ahead?

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

So, Wes, I mean, thank you Wes and Liz, thank you for your comments there. I mean, certainly we understand that the timing at this point may not have been the best, but we have to start somewhere and essentially right now the program that we're operating under is the 2014 edition certification criteria so we need to start here in order to prepare ourselves for Stage 3. Certainly Stage 3 isn't here yet and while we understand that there might not be as much input as there would have been 6 or 8 months ago or even a year ago we have to start somewhere and certainly with this –

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

Yeah, but –

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

Let me finish for a second, with this approach there are a lot of vendors that we think will participate. Certainly there are those that will update their products that need to go back through additional testing and certification to get those products, you know, updated for the various versions that they develop and this will be an option for them.

So, while it may not touch or have the option to touch 100% of the vendors that are out there, you know, even if it does touch 10, 20 or 30% those that decide to go back through the program have that option to. So, we want to give that – we want to avail them of that opportunity as quickly as possible.

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

So, Scott, I mean – I think we all like the concept. I mean, obviously we like it we're the ones who tried to get it going, you know, a while back, but I – and I'm not – so don't misunderstand me I'm not objecting to it. I just don't want us to expect that people are going to pay to be certified again. I mean, I'm just being honest.

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

This isn't – we're not – this is not a forcible program, so this is certainly optional. We're not suggesting that anyone have to go back through and repay to be tested under the testing scenarios. The idea is to offer an option.

So, for example if a product is updated to support additional tests or additional options that vendor has that option to say, you know what we want to go through the testing scenarios and that the ACO or ACB has the option to then offer that to them at a faster time rate and potentially a different cost.

**Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology**

And the other thing is – let me just say this, we have got – in order to use a process like this for Stage 3 we've got to have some solid data on how it works and what we need to do, and how to put it together.

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

I agree.

**Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology**

And the only way we can do that is using what we have which is Stage 2 to do that and so if you think about it as an experiment or, you know, just using the data that we have that's what it would be. I do believe, as Scott said, that there will be people who use it but, you know, even if they don't in order to implement it for Stage 3 we've got to go through this process otherwise we're going to be in the same boat in Stage 3. We've got to do it and be ready to roll –

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

I hear you.

**Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology**

When we do get the criteria for Stage 3. So, that's really, you know, whether or not people use it is a different issue from whether or not we need to test the process itself.

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

Yeah, so I think, you know, not to speak for the chairs, but I think they have to make a determination what kind of effort we can amount in advisory and that depends on our ability to get information, to get participation from vendors given that it's water under the bridge.

I have questions about whether retesting typically involves retesting all scenarios or one specific, I'm sorry, all current tests or one specific test. I suspect that the accredited testing bodies work with the vendors to minimize the retesting caused by new features that come out. In that case I'm not sure that they would want to go back and essentially retest functions that have already been tested. The only outcome there is not a good one.

So, we understand – I would say I understand that you need to proceed along this course. I would say we don't know how much help we can give at this point, but hopefully we can find some middle ground.

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

Right.

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

Again, I hate to speak for chairs, but –

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

No, I think you're right. I mean, we want to help. I think you've expressed, you know, where we are and like you said – I agree with you guys it's a great point that we need to do something to get ready for Stage 3 complete concurrence for that.

Maybe what we need to do is back off for a day or two, give us a chance to talk. I mean, I can see an opportunity to get, like you said, you know, at least Epic and Cerner representation and I'm not trying to exclude them or say they're the only vendors but they're certainly major vendors in this arena and then we need to do something on the EP side involved.

And then I think we need to hear from the certification bodies. I mean, are you working with them? Like when we – like Wes eluded to, when we do new things like even with our EDW we just test for that specific thing we don't start over. So, maybe we could – I mean, are you Carol – are you and Scott working with the certified bodies, the certifying bodies?

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

Liz, we've been comparing with them throughout this entire process, we utilized them this summer when we conducted our initial pilot. Certainly, part of our rollout for this has been communicating with them all the time and then indicating where they can go and view the draft and develop testing scenarios. So, they've been aware of this and are involved in looking and reviewing.

My illusion in the first, you know, portion of the presentation was that we've opened this up for feedback and review and haven't received much as of yet from all parties, they're available on our website for public consumption it's not that you need to have a special key code or we're opening it up to only one person, we've done our best to develop this in a public arena as opposed to in a vacuum.

So, our goal in introducing it back to the Workgroup today was to say, hey, we understand that we've talked about this, we would like your feedback in whatever way that's possible. Certainly, if you have other contacts and can forward the website to them and say, hey take a look at this; send us a note that would be fine.

If you wanted to do it in a more formalized way in developing the groups that Carol talked about or subgroups within the Workgroup that's fine as well, but at this point, you know, we're kind of at a place where we need to get – where we would like to get feedback and we would like to get, you know, additional support with this, but if we don't get much more we're going to have to kind of continue down that path that we've described and we shown on slide 3 where we continue and work through our next pilot phase, and we work to getting these approved and instituted in the program.

So, certainly, it's – we understand that – you know, we want as much feedback as we can and we've opened this up, but we haven't gotten – we haven't gotten the folks to kind of connect to it as of yet. So, if you guys could help us through that and you want to support it then that's great but we have to continue moving forward with it.

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

Okay, so here's what we'll do and I don't know if Cris – I know Cris had to step off at the top of the hour, I'm not sure if he's still – Cris are you still with us or have you stepped off?

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

I'm still here, but please lead us.

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

Okay, so what I would suggest is that Cris and Anne, and Wes, and myself, and a few others need to kind of put our heads together and say, okay, how can we really help and we'll feed that information back to Carol and Scott, and Seon, and I just think we need to step away from it and determine how do we move forward.

And then the other thing that would be really helpful is if you have any kind of simple documentation as to who has participated in the pilots and what specific feedback you've gotten, because we're going to try to add to that feedback not – I mean, it always re-enforces if you get the same feedback but it's difficult – I feel like we sort of keep talking out of context because the work continues to – with ONC which is terrific, you know, we're sort of sitting on the outside and could be suggesting something that's already been done because we're just not as connected as we might be. So, that would be my suggestion to the group. Cris, Wes, Anne any – are you okay with that moving forward?

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

Completely support, Liz, thank you.

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

I'm good, I'm good, it's Anne.

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

Okay, good and Wes you okay with that?

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

Right on.

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

Okay then that's what we'll do guys and thank you for taking the time to put this together and to – I think we're much better informed now as to where we are and how the process has proceeded and we'll put our heads together very quickly and determine then how the Implementation Workgroup going forward can assist you further and we'll – again, thank you and if you want to – Caitlin if you want to open it up for public comment please or Scott?

## **Public Comment**

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

Yes, let's open up for any public comment if available, please press 1 on your phone or \*1, I apologize.

**Caitlin Collins – Project Coordinator – Altarum Institute**

And if you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. We do not have any comment at this time.

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

Well, thank you and thank you Scott and Carol, and Seon for getting the information together for us and to the Workgroup members that were able to participate and several of you I'll see in Washington tomorrow and we will get back to the folks at ONC with our next steps. Everybody have a great day.

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

Thanks everybody for your time.

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

Thank you, bye-bye.