Implementation Workgroup
Draft Transcript
July 12, 2012

Presentation

Operator

Ms. Robertson, all lines are bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everyone, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee's Implementation Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself before speaking. I will now take roll. Liz Johnson?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Liz. Cris Ross?

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

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Cris. Robert Anthony? Kevin Brady?

Kevin Brady – National Institute of Standards and Technology – Principal Investigator, IIEDM

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Kevin. Anne Castro?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Anne. Simon Cohn? Tim Cromwell? John Derr, I know, won't be able to make it today. Carol Diamond? Timothy Gutshall? Joseph Heyman? David Kates? Tim Morris? Nancy Orvis? Steven Palmer?

Steven Palmer - Texas Health & Human Services Commission

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Steven. Wes Rishel? Kenneth Tarkoff? John Travis? Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Micky. Gary Wietecha? And Joe Heyman, are you on the line?

Joe Heyman – Whittier IPA
I am.

MacKenzie Robertson – Office of the National Coordinator
Okay, thanks, Joe.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability
Oh, fantastic.

MacKenzie Robertson – Office of the National Coordinator
And is there any staff on the line?

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst
Scott Purnell-Saunders.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Scott.

Carol Bean – Office of the National Coordinator – Director, Certification and Testing
Carol Bean.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Carol. Okay…

Chris Brancato – Office of the National Coordinator
Chris Brancato.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Chris. All right, Cris, I'll turn the agenda back over to you.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability
Thanks and good morning everybody, this is Cris Ross. Our agenda today is pretty straightforward, we met two weeks ago, we discussed medication management testing scenarios and today we're going to talk through the inpatient and outpatient scenarios. Glad for all the clinicians who can be on the call today in particular. Just as a quick preview and ONC staff should speak up here as appropriate too, if you were not able to be at the first meeting I just want to do, you know, a brief overview of what we were doing.

These scenarios are intended to conform test scripts to be used for the testing process; they are not a substitute for scripts and so on. We had a lot of discussion about the way to think about scenarios as a way of putting realism and rationality into the test scripts as an improvement over what we were able to do in Meaningful Use 1, specifically ONC walked us through a couple of scenarios or a couple of approaches for how to use these scenarios to make sense of the script.

But our underlying goal here was to make sure that when we're testing an application it meets the Joe Heyman test, you know, is it doing something that makes care better, are we not just doing testing just for the sake of testing, are we really representing the way that clinicians actually act on a day-to-day basis, Joe sorry to sort of quote you, but you've been such a steadfast and clear voice on that, I think we've really taken to heart the issues that you and other working clinicians have raised.

So, medication management testing scenario, we reserved about 15 minutes to just review feedback on that. We didn't distribute a document associated with that, I think the only documents that came out with the agenda today are inpatient and outpatient, which is fine, but it would be worthwhile for us to just make sure that we don't have additional feedback on medication management. So, before we do that I want to do two things, one is ask Liz if you have any comments and two, if ONC staff would like to improve on or contradict the framing that I just did about the purpose of these scenarios relative to test scripts?

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

Thanks, Cris, no, the only thing I would say that given that we have Joe, we have you today, we may want to go to outpatient first.

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

Right.

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

Because that's I think Joe where you will be just critical to our discussion, so that would be the only modification, because I do not think we can possibly get through more than one, because we really have about 40 working minutes.

Joe Heyman – Whittier IPA

You guys are making me feel very…

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

Yeah, no pressure, Joe.

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

We hope we're making you feel…you're understanding how important you are to us.

Joe Heyman – Whittier IPA

Yeah, right.

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

That would be all, Cris, thanks.

Chris Brancato – Office of the National Coordinator

Cris, this is Chris Brancato, if I could just elaborate your frame just a little bit.

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

Please do.

Chris Brancato – Office of the National Coordinator

What we'd like to do is just make everybody aware that why we want to put a sense of realism in these things, we recognize, you know, very clearly that workflows can be very divergent, I mean on what type of practice you're in and the environment you're practicing in, so what we we're after is to create scenarios that are plausible more than trying to address any one specific workflow scenario. So, as you review these if you could put that lens on your review we would appreciate that.

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

Yeah, Chris, that's an excellent point, because obviously we're not trying to enumerate like every possible use case for inpatient or outpatient scenarios, we could be here for a very long time. I think that's a good point. I think when we walk through medication management we really highlight, well these are the most common kinds of tasks and these are typical ways that these activities are strung together as opposed to saying, well, you know, there's five different sub variations of how you could do this and I thought we had a pretty good discussion.

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

Yeah, I think the other thing we have to remember is that these things will have to be…we have to continue to do unit testing for the fact that we modular, so it is not a substitution for other types of testing, it is in addition to.

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

Right, right.

Chris Brancato – Office of the National Coordinator

The other one, Chris Brancato again, the other ones that I think I'd like to put on this for you to think about is who is using these and that's engineers, test engineers, product managers, those kinds of people are using these documents. So, we'll get to some refinement as these documents develop, but I think some idea of, you know, as clinicians we'll sit here and say, well everybody else will understand what we mean by this until we put it in the hands of an engineer who has no idea what we're talking about.

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

Exactly. All right, I think maybe the last comment would be, this is Cris again, that, you know, the determinate thing, the regulatory, you know, gold standard here, is really the test script that each EHR needs to go through, but these are intended to be sort of a frame to help support those, but at the end of the day, certification is because it can pass, you know, a specific test script.

So, let's go to medication management testing scenario feedback. I guess my question would be to open it, actually even before we do that, committee members do you have any questions or comments about what we're about to do?

Joe Heyman – Whittier IPA

This is Joe; I'm just wondering is there something that I'm supposed to be reading?

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

Yeah, it went out in the e-mail this morning.

Joe Heyman – Whittier IPA

Okay, I'll find it. I got it.

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

Yeah, in particular if you could open up the outpatient scenario and agree with Liz that we'll start there, but good question.

Joe Heyman – Whittier IPA

Okay and the other thing I want to point out is that those engineers who won't know what we doctors are talking about they're going to feel exactly how I feel most of the time on these calls.

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

So, it's kind of about fair play.

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

Yeah, that's right, turnaround, fair play is right.

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

All right, so let's talk about medication management, I guess I would open it to do people have any further comments, questions, reflections on medication management? Folks from ONC can you remind me did we send out an annotated version of the medication management testing scenario based on our last meeting? I'm looking quickly and I can't find it.

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

No the original, this is Scott Purnell-Saunders; the original document was the only one that was sent out.

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

Great.

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

Yeah, Cris can…so can we, this is Liz, can we request that because it's really…I mean, I know y'all understand because your jobs are the same, between meetings I have a hard time remembering everything we said other than from my own document and I just want to be sure that we capture the input and that way we wouldn't repeat the same things, you know, over. Is that possible, MacKenzie? Or, I'm not sure if I'm asking the right person.

MacKenzie Robertson – Office of the National Coordinator

Sure, did you want notes that Scott would be taking during the calls or are you looking for like the transcript or meeting summary afterwards?

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

Well, I would like the notes associated with each…I don't know if it's possible to either build the notes specific to the script where we could match, so if we said on, you know, page 3, paragraph 4 we'd like these things considered or added we could match them back up, because if we just look at a summary I think we're going to have a difficult time doing the correlation.

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

Yes.

MacKenzie Robertson – Office of the National Coordinator

So, Scott, are you capturing that, that we can have it distributed afterwards?

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

Yeah, I'm working on that now.

MacKenzie Robertson – Office of the National Coordinator

Okay.

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

Great.

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

Yeah, I would propose specifically, this is Cris, if at all possible if there was a way that just red line the Word document to throw in a comment to say there was discussion here about such and so and such and so and therefore this improved language was proposed, if there was a redline insertion around that, that would be at least one way to do it, right? So, that we would have from first meeting then we would have a red line version to say here was the feedback from the working group and then perhaps a final version that deletes the notes and accepts the red line changes, right? And that would be the test scenario that then would move forward. Does that sound like a reasonable approach?

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

Scott, I think we're asking you.

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

And I'd agree with that.

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

Okay.

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

That would be fantastic.

Joe Heyman – Whittier IPA

This is Joe, I'm just trying to figure out which document I'm supposed to be looking at, three documents came this morning?

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

Well right now we're looking at medication management and we're going to look at outpatient eligible provider.

Joe Heyman – Whittier IPA

Medication…

MacKenzie Robertson – Office of the National Coordinator

I think it starts with OP, Joe.

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

Yeah, I don't think we got to medication management document.

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

Oh, I beg your pardon, I'm sorry.

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

Yeah, so, OP is the one we'll go to. I think we're probably not going to have much of a discussion about medication management. I think in a perfect world if we had a red line version of it, and when we do this again, if we could have a red line version on the outpatient and inpatient, then in this meeting we would take a look at that and people could comment on yes that reflects the nature of the conversation and so on and we could approve changes. So, without that I would suggest we move onto the outpatient eligible provider test script. Does that make sense to you, Liz?

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

It does, absolutely.

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

And then we can have either Chris or Scott walk us through that.

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

Yeah, perfect, Cris and I think that way next time we'll have an annotated version of both and we'll be able to start there, perfect.

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

Yeah, I think the annotated version would really help us.

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

It will.

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

All right, so Scott or Chris or someone else, are you going to walk us through this? I think Chris you were the author of this.

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

Yeah, Chris I will let you start and I'll keep track of where we are and I'll add things as needed.

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

Thanks, Scott. So, Chris can you walk us through this?

Chris Brancato – Office of the National Coordinator

Yes, I'm sorry, I was talking to the mute button as usual. My computer…I'm struggling to get the document open, so I apologize for that, it crashed in the middle of the preamble here.

MacKenzie Robertson – Office of the National Coordinator

This is MacKenzie; I'm going to have them upload it onto the Webinar too, so…

Chris Brancato – Office of the National Coordinator

Oh, okay.

MacKenzie Robertson – Office of the National Coordinator

But, it will just be a moment if that is easier.

Chris Brancato – Office of the National Coordinator

Yeah, that'll be good. I apologize for the delay. I'm in the middle of a reboot cycle.

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

No, that's fine, Chris, I'll start and you can catch up once you're back up and running.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Okay, thanks.

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

So, with the outpatient document that we're looking at, we'll start with the purpose, purpose scenario-based test script is to turn the electronic health record in a manner that reflects typical clinical workflow to ensure that as the required data is collected it remains threaded. So, the big thing with all of these has been that information that starts in a particular scenario will continue through each of these particular steps. One thing that we explained on the last call that I will reiterate again here, is that, and we talked about it a little bit earlier, but these scenarios are not to replace unit based testing but are more to supplement. The idea with these tests is also that there are certain parts of these scenarios that may in fact be skipped or not tested for a particular product.

So, in a lot of cases we're looking for feedback and help with making sure that these scenarios reflect actual workflow and that, you know, the pieces that we think that can be substituted or can be skipped will in fact be able to be done that way. So, you know, so by way of example if the information is collected and appears in a patient's problem list that is to reference 170.302(c) maintain an up-to-date problem list, it is expected that this information will be available and used by the EHR to generate a patient reminder list, that is 170.304(d). So, just showing how their information passes back and forth.

Test methodology, testing is performed in a sequence of iterative steps to be completed one after another to match the workflow described. And sequence and scenario the EHR would have demonstrated its ability to perform both scenario sequence and the individual certification criterion tested during the scenario sequence as well. There are a couple of assumptions listed below, basically that the person who will be running the test is authorized to do so and will in fact be an engineer or technician as we described a little bit earlier.

The certification criterion tested, right after the pre-conditions is listed below and I'll let you guys kind of look through that and we are looking at the pre-conditions being the scenario of the typical workflow that occurs at an eligible providers site of care and the actors need to be basically based in that particular workflow.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

So, Scott, this is Chris Brancato, let me jump in just for a second, I'm back on line. For, Dr. Heyman's benefit and the other members who were not on the call, the test methodology it is important to point out that while the intent is to have the tester complete the sequence that does not imply that the EHR has to complete every test in sequence. So, we recognize that every EHR has to meet the base EHR functionality but their functionality beyond the base may not be part of the testing sequence, if that makes sense to you. So, the…

Joe Heyman – Whittier IPA

So, this is…I'm sorry.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

The test is written so someone could drop a criteria out of this sequence if it does not apply.

Joe Heyman – Whittier IPA

So, this is Joe, I completely admit to you that I do not understand all of that testing stuff. My question is you gave an example with an up-to-date problem list and that it should somehow be linked to the patient reminders, could you give a more, sort of a graphic description of what you're saying from the physician's point-of-view, I just don't understand what that means.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Sure, so from a physician's point-of-view in this case there are data elements that live in the problem list and if you refer to the criterion one of those data elements has to be used to populate the patient reminder list and the patient reminder lists are here's somebody who's problem list is, you know, primary diabetes mellitus type 2, initial diagnosis, uncontrolled and that populates your reminder list when you search the EHR and say, I need to bring back all of my initial visit, each one, I mean diabetes notice type 2 who have not had an A1c in the last 3 months.

Joe Heyman – Whittier IPA

I see, so basically what you're doing is you're using the element in the problem list to identify all the patients who have that particular problem?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

That is correct.

Joe Heyman – Whittier IPA

So, if somebody forgets to put something in the problem list, but they have a problem someplace else that is talked about in their medical record and listed somehow as a diagnosis they would not be found?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Well, not necessarily because the problem list can be generated, I mean, excuse me, the reminder list can be generated off of more than just the problem list.

Joe Heyman – Whittier IPA

I see, so you're making as a minimum that it has to be generated from the problem list?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

It's not a minimum, it's an example more than anything else, the criteria elaborates four different sources of data that should trigger into the reminder search.

Joe Heyman – Whittier IPA

Okay and this is just one of them?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

This is just one, yeah.

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

Yeah and, this is Cris Ross, I think also one of the things in slide here 2 is that the reminder list would be key to the problem list so that you wouldn't see, you know, an all inclusive reminder list of everything you could possibly do with that patient regardless of problem or diagnosis and so on, right? So there is some connection between the two to make the workflow work better for the clinician, that there are not irrelevant reminders in place. Is that also implied here?

Joe Heyman – Whittier IPA

Is the reminder list a formal list that a doctor is going to have that they don't have now or is the reminder list just the potential problems and then a physician would be able to pull a report? I'm just trying to understand how this is going to work in the real world.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Well, in my experience every EHR that is ever used clinically has had the ability to be able to perform some query on the database, again it's the patient panel, and pull back specific patients that meet a criteria.

Joe Heyman – Whittier IPA

Right.

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

Right.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

So, I think some of your question, Dr. Heyman was, does the information that gets pulled in need to be encoded or…

Joe Heyman – Whittier IPA

No, that I understand that it would, it seems to me it would need to be encoded wouldn't it?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Right, no it does not.

Joe Heyman – Whittier IPA

Oh, it doesn't.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Well ideally we would want it to be correct?

Joe Heyman – Whittier IPA

Yeah, it would seem that way, but…

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

But…

Joe Heyman – Whittier IPA

But it doesn't need to be?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

It doesn't need to be, it's a functionality I'm familiar with and I've seen it be able to do text searches with less, so…

Joe Heyman – Whittier IPA

I guess what I'm asking is: What is the definition of a reminder list? What is a reminder list? Is it a list of potential issues or is it a report that somebody generates because they're looking for something in particular?

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

Well, Joe, generally speaking, where we've used this as far as interpretation is, a reminder is the ability that EHR has to assist the physician in being able to either generate a direct reminder to a patient about something that they need to follow-up on or to a clinician like yourself or someone in your office to get to, you know, follow up, that is really how we've used this in this context.

Joe Heyman – Whittier IPA

No, I understand that that's what a reminder is.

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

Okay.

Joe Heyman – Whittier IPA

But what I don't understand is what a reminder list is. I understand what a reminder is.

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

Yeah, I got you, I'm sorry, I'm with you.

Joe Heyman – Whittier IPA

What is the list part? That's the part I'm…

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

Yeah, and that's a good question because generally speaking…is that how it's listed Chris in the Reg as a list?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Well, it can be, it doesn't necessarily talk about, you know, what format the retrieve data looks like, it could be a printed list, it could be an on-screen presentation of all the patients meeting that criterion.

Joe Heyman – Whittier IPA

Okay.

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

Okay.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

It's not that prescriptive.

Joe Heyman – Whittier IPA

Okay.

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

So, it could be on demand?

Joe Heyman – Whittier IPA

Yeah, I guess the only thing I would say is that most of us don't think of them as lists, so.

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

Right.

Joe Heyman – Whittier IPA

I mean most of us physicians don't think of it a list, we think of it as a report, you know, that we…

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

This, Chris Brancato again, this is one of those things where the rule contains the word list.

Joe Heyman – Whittier IPA

Gotcha.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

And that's…so one of the things that we went after and we discussed in the last meeting was making sure our semantics are correct from the rules of the test procedure to the scenario basically.

Joe Heyman – Whittier IPA

Okay, well that makes me feel less guilty for stalling everything by asking that.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Not at all.

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

So, this is Cris Ross again too, I know we're not going to get into this level of detail, but Joe, specifically if you wanted to follow that on page 4 of this document where it lists the certification criteria tested.

Joe Heyman – Whittier IPA

Yeah.

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

And 170.302(c), you know, if you look at that PDF it goes into great gory detail about what the requirements of a problem list is. I've been looking at that as we've been talking as a non clinician just to make sure this makes sense.

Joe Heyman – Whittier IPA

Okay, great.

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

I think your point is a very good one. I think the word list is used pretty broadly.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
Yes.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability
But it's intended to incorporate, you know, reports and lists.

Joe Heyman – Whittier IPA
Okay.

Kevin Brady – National Institute of Standards and Technology – Principal Investigator, IIEDM
This is Kevin Brady from NIST. Chris, are you going to provide test data for each step of this if they can skip steps, you're going to need it.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology
Yeah, I'm not prepared to discuss that right now.

Kevin Brady – National Institute of Standards and Technology – Principal Investigator, IIEDM
Okay.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology
…

Kevin Brady – National Institute of Standards and Technology – Principal Investigator, IIEDM
But you're thinking about it is all I want to know.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology
Yes, we are actually thinking about it.

Kevin Brady – National Institute of Standards and Technology – Principal Investigator, IIEDM
Okay, good.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology
Thanks.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability
Excellent, so Joe you were asking questions about, you know, the context for this, do you want to pursue…is there more to pursue there, or should we have Chris and staff walk us through it?

Joe Heyman – Whittier IPA
No, just continue on.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability
Yeah, that's good.

Joe Heyman – Whittier IPA
I don't like this to be an all about Joe call.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability
All right, Chris and Scott can you take us to the next section?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Yeah, sure, so just looking through this, this scenario really is meant to take a plausible typical outpatient provider's office, which is an adult patient we're talking about and essentially what we wanted to do was represent the different people or job roles that would be taking care of this patient as they move from registration to the visit, to post visit kind of scenario. So, you'll see we've chunked them up into a pre-visit scenario and then what you see listed there are the criteria that could be tested as a result of a pre-visit sequence.

Obviously, if you look at the visit sequence you have the bulk of the criterion that we want to get and test, and to get as much of the data that can be threaded from…criterion to criterion we will do that. Again, that is a conversation that we at ONC have to have off line on what that test dataset actually looks like, but we have some pretty good ideas of what it will need to represent in order to achieve this goal.

And then the post visit sequence is some of the things that happened after the clinicians, the primary clinician has already seen the patient and then, you know, follow-ups and other Meaningful Use related activities that would need to happen so the physician could demonstrate that they are meaningful using their EHR. So, the next set of sequence in the document essentially sets up the scenario and actually puts some functionality constraints about…which are consistent with what's in the test criterion today for each criterion, you'll see for example after being away from the EHR system for 10 minutes the system automatically logs off. Well, if that plugs directly into the automatic log off certification criteria it is set.

And then all of these criteria you see in the visit are pulled directly out of the certification criteria. You can see now how these things are starting to thread together and start to…this almost serves as a middle layer across all of the criterion, criteria, excuse me. So, if you want to take a moment to look through that, I tried to make it very short read, you know, and still make it plausible, so I'd like some feedback on these three sections if you don't mind.

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

So, let's start with just the scenario assumption, is there anything exceptional or incorrect about the assumption, then we'll go to the workflow. Does anybody see anything remarkable about scenario assumptions?

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

I mean, obviously it only test a very specific scenario because you're talking about initial visit and you're talking about adult patient. Hey, Chris, was your thought that if you could do this then you could meet the full set of criteria?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Well, viewing the lens of what I looked at you would meet the base functionality if you completed the scenario with all of these criterion.

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

Okay, yeah, because the only one that just really jumped out at me of course is advanced directives, we obviously wouldn't necessarily have an advance directive on a 23-year-old, not that that matters, maybe we could just show how we used it, we can get that there.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

And again, if we were going to do this in an actual test scenario that could fall out of this but that doesn't mean that the vendor is off the hook.

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

Right, right.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

They would just need to test that out of sequence.

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

Right, Joe, so when we were talking about this last time one of the things that we talked about was trying to…obviously this is for vendors but also for those, like yourself, where you're trying to show your own software works, so we were trying to make it palatable but also meaningful from a clinical perspective.

Joe Heyman – Whittier IPA

Righto.

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

Okay, so I think I'm okay with assumptions, how about, Joe?

Joe Heyman – Whittier IPA

Yeah, are the assumptions that list of numbers or are the assumptions…?

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

No, I think…Chris did you mean a scenario of assumptions?

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

They list assumptions on page 5 just so we can walk through it…

Joe Heyman – Whittier IPA

Scenario assumptions you mean?

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

Yes.

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

Yeah.

Joe Heyman – Whittier IPA

Yeah, I'm comfortable with that.

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

And it seems pretty straightforward, is this atypical, it doesn't seem like it.

Joe Heyman – Whittier IPA

No.

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

I think the next thing we should probably walk through is just the workflow, the idea of the three phrases and then the specifics within those phrases. So, the stuff that's on page 6.

Joe Heyman – Whittier IPA

The only thing that popped out to me, this is Joe, was that it may not happen in that order, in other words during the visit sequence a problem might be identified at the very end of the visit rather than at the beginning, but I don't know that they're even in a sequence, I think they're just there to be bulleted so we make sure they're all included, is that right?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

That is correct.

Joe Heyman – Whittier IPA

Okay.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Yes.

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

And then we can trust, Chris, that this is all inclusive, because I know I don't know off the top of my head, Joe I don't know if you know?

Joe Heyman – Whittier IPA

It looks pretty inclusive.

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

Yeah, me too, but, you know, you kind of…

Joe Heyman – Whittier IPA

I don't know if it's got everything that is in Meaningful Use, but…

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

Right, so we're counting on you, Chris.

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

Yeah, that would also be the feedback to the group is, you know, if we have missed something here and you guys…it becomes really egregious, say something.

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

Oh, we will.

Joe Heyman – Whittier IPA

You know, one of my concerns about Meaningful Use and the requirements is that patient specific education resources, you know, not every EMR is going to have the right resources for every patient and I find myself giving out a lot of stuff that's not in my EMR, and there really is no way to count it unless I'm actually going to make a separate list and count every single one where I give a patient something and it is a nuance, so I'm just putting that on the record, because the implication is that somehow the resources within the EMR that the EMR is capable of counting are the appropriate resources for every patient, usually they're just one pagers and, you know, I've got pamphlets, I've got all kinds of things that I give to patients.

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

So what's the test provision, this is Cris, what's the test provision for, in Joe's case, or anyone else's where they have external material, you know, to do a check box indication which is, you know, I provided patient education materials not supplied by the EMR, presumably that's something that would allowable and testable for certification purposes and for attestation purposes for a practice to prove that they met the numerator and denominator goal, is it fair?

Joe Heyman – Whittier IPA

Yeah, I think if there were a way to just document, you know, that if there were…for example in my EMR there is a place for indicating that you gave the patient specific educational resources. A lot of times I free text in there that I gave them an IUD pamphlet for example, because what's within the EMR is just a single pager that really is not adequate for giving the patient the stuff they really need for that as an example. So, it would be good if just the fact that I entered something there would automatically count even if it was free text, you know, just so that I don't have to do something extra.

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

This is Carol; let me ask a question, if I may? If we're testing the capability of an EHR is this a workflow versus capability question? If the capability, the functionality is that the EMR has to, you know, provide the patient specific recommendations and the educational material, and the physician chooses not to follow that, I'm not real sure how we get from the physician making, you know, a clinical decision compared with the capability of the EHR to do the function.

Joe Heyman – Whittier IPA

All right, I guess that's a good point, but I guess my point here is that you have to indicate that you've done a certain percentage of your patients with this stuff and it becomes one of those exercises where you're just doing something for the sake of measuring something rather than actually helping the patient in some way.

Carol Bean – Office of the National Coordinator – Director, Certification and Testing

So, that sounds to me then like this is more a matter of the Meaningful Use measure may or may not be appropriate versus the EHR or perhaps the vendor hasn't…of that component hasn't done it in the way that the clinician would like to do it. I understand your point, I'm not sure…what I'm trying to do is figure out how to get…

Joe Heyman – Whittier IPA

I understand your point and what I would say to you is you're probably right and that it has nothing to do with what we're discussing except that you have to understand that as a clinician this is my only opportunity to make these points so sometimes I do.

Carol Bean – Office of the National Coordinator – Director, Certification and Testing

I'm just…thank you.

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

This is Cris. I think we're into some of the detail about what the specific test standard would be right? And I think that's fine for us to talk about that I think we're trying to think about how the scenarios work to support that, but I think it's useful to understand, if someone on the phone knows, does the Meaningful Use requirement, for example, say that the clinician needs to provide materials from their EHR or only that they need to provide materials which they record in their EHR, right? It's one of these cases of where the Meaningful Use requirement and the certification or Meaningful Use test and the certification requirement may not be entirely identical.

John Travis – Cerner Corporation

Or for the patient education, this John Travis with Cerner.

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

Hey, John.

John Travis – Cerner Corporation

Interestingly enough I just had a conversation this morning with Rob Anthony on what counted for numerator qualification for patient education. The provider, the system suggests to the provider the materials to be used, the provider does have the latitude to, you know, having seen the suggestion go, you know, I know of something better, maybe I read an online article in JAMA that is more relevant to what I want to educate the patient about, I'm going to go pull that in. So, at least in the Stage 1 objective if the provider chooses to ignore what was suggested by the system and provide some other educational materials to the patient they still can claim numerator credit, but that's a case where from a measurement perspective, you know, the measurement is of the provider's action to do the education not necessarily that they solely relied on what the system suggested.

From a certification stand-point, you know, the vendor has to demonstrate how the system suggest educational materials and for measurement at least how they would record the knowledge that the education happened, but unfortunately there is nothing the system is going to necessarily know short of the provider having documented that the education occurred and because it could occur, so to speak, using materials out of band from the system, then we don't have an ability to definitively know that we have to rely on the provider bringing their procedural understanding of how to comply with the numerator requirements to the system to record that.

So, that was an interesting conversation, because, I mean that's pretty much what I thought, because there is a statement in the FAQ on patient education, the very last statement, that gives the provider that latitude but that was an affirming conversation.

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

…extremely helpful.

John Travis – Cerner Corporation

…are definitively going to have different tests, the system can't presume what the provider is doing, you know, you have to operate within the realm of what the system can do.

Joe Heyman – Whittier IPA

So, I'm understanding now that in meaningful use 2, or maybe it was even in meaningful use 1, that the system itself has to suggest that there are educational materials available for that particular diagnosis or…?

John Travis – Cerner Corporation

Yeah, it's in the context I think, and Carol you could correct me, I think it was based on demographics, problems, medications, lab results, maybe I'm missing something, used singularly or in combination that the system was capable of making suggestion.

Joe Heyman – Whittier IPA

Ah ha.

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

Yeah, and that…

Joe Heyman – Whittier IPA

Well my system does not do that.

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

And I was going to say, I think that is Stage 1 actually.

John Travis – Cerner Corporation

Yeah, it is and you know it could be as simple as…it doesn't have to be a bang you over the head dynamic alert, it could be I'm looking at meds and I see a link available to the drug monitor addressed, it could be on the departure based on the patient's discharge diagnosis, the system might suggest links to available reference materials for their condition, you know, diabetic care or whatever.

Joe Heyman – Whittier IPA

Does it suggest a specific link or it just says "do you want to give educational material?"

John Travis – Cerner Corporation

The system has to provide some kind of…I would guess that the frontier, and it may get gray, is that it's at least providing guidance to the search for the materials.

Joe Heyman – Whittier IPA

I see.

John Travis – Cerner Corporation

And it doesn't have to generate them or store them itself, but I think it has to provide direction on, you know, whether it's a link or it's a phrasing to say, you know good resources for this might be the AMA's guideline on…

Joe Heyman – Whittier IPA

Gotcha.

John Travis – Cerner Corporation

Juvenile diabetes or something of that nature. I mean, I think you…

Joe Heyman – Whittier IPA

Well that sounds great to me, that part sounds great.

John Travis – Cerner Corporation

I don't know, Carol, how far you would constrain that statement to say, you know, when we went through certification our example in particular was we did suggest materials, you know, either through links or through things you could pull in to a, you know, a discharge summary note that you'd give the patient upon departure. I can't speak to other system behaviors, but where you draw a line between the system making a suggestion and in a fairly literal way and a system suggesting something in a metaphorical way.

Joe Heyman – Whittier IPA

Well, I've noticed my ePrescribing program does make a suggestion every time I do a prescription and sometimes I actually take them.

Carol Bean – Office of the National Coordinator – Director, Certification and Testing

Absolutely.

Joe Heyman – Whittier IPA

However, it doesn't work that way in my EMR.

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

Hi, this is Anne; I'm usually useless on these calls, however…

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

You are never useless.

Joe Heyman – Whittier IPA

Not so much.

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

While you all have been talking I have pulled up the CMS Reg and it says that it needs to use the problem list, medication list or laboratory test results to identify the patient's specific education resources and that education resources or materials do not have to be stored within or generated by the certified EHR, however, the provider should utilize certified EHR technology in a manner where the technology suggests the patient specific education resource is based on that information.

John Travis – Cerner Corporation

Yeah, it probably is all how you interpret suggest, you know, and I think certainly the system providing a link to a drug monitor…on a medication list would meet that test, the system saying "hey, I see that this patient has got a problem of diabetes, here's links to materials or here's…" provide those certainly meet it, but is there…

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

It's like there needs to be a library that correlates to…

John Travis – Cerner Corporation

Something like that and it could be a link to an external reference source, I think that's what they're intent of you don't have to store or generate it, the system is not physically the repository for the materials it's pointing you to a place you could go find them.

Joe Heyman – Whittier IPA

Sounds great.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

This is Chris Brancato, I'm just going to walk something around this for a moment, the criterion will never be as prescriptive of a specific vendor on how you achieve the criterion, it just says what the minimum requirements are of that criterion. So, you know, through testing ONC has seen a variety of different flavors of how vendors chose to meet this criterion. Does that make sense?

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

Yeah, so this is Cris Ross, I think that this is a good discussion; I know I'm learning a ton, it sounds like other people are too, I just want to make sure we're staying on task here, that was great education about what the certification test requirement is. I want to see, we've got about 13 minutes left, I want to see if we can circle back to how that relates to our scenarios.

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

Hey, Cris, remember we've also got to get in public comment.

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

Exactly. So, I think we've got about, you know, 10 minutes left to work through some materials here.

Micky Tripathi – Massachusetts eHealth Collaborative

Cris, this is Micky Tripathi, I've got just a couple of comments on the workflow activity list here.

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

Great, thanks Micky.

Micky Tripathi – Massachusetts eHealth Collaborative

Well my biggest contribution might be that there is a typo that will elude the spell-check, advance directives is says advanced directives.

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

There you go.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

I appreciate that.

Micky Tripathi – Massachusetts eHealth Collaborative

So, yeah, I think that's my most important contribution, but the other one is, I don't see any of the…you know, the two…in Stage 2, you know, two of the biggest changes are the patient engagement objectives.

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

Yeah.

Micky Tripathi – Massachusetts eHealth Collaborative

So, I don't see the secure messaging or the view, download, transmit here.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Micky, this is Chris Brancato; we purposely stayed away from most of the Stage 2 recommendations for this scenario recognizing of course that every scenario is going to need to be updated once the rule become final. If that criteria exists in the final rule it will be reflected in all the test scenarios.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

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

So, I had a question about that generally too, and maybe this is a comment more than a question, based on what Micky was saying, was the activities that the clinician would do to engage with the patient when the patient is not in the office, which relates to all the things Micky just said and they could be other kinds of things, you know, provider generated, you know, reminders and, you know, ongoing education materials for a patient, you know, whatever that might be, are you anticipating including those as well or is this specifically going to be aimed at an outpatient visit per see as we know it?

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Chris Brancato, we could very easily anticipate those things, in this scenario in particular the patient actually filled out the family history form, the history of present illness, the past medical history all off line and before the visit. So, things like that, as just one example, could very easily be put within and nest within the scenario recognizing that ultimately the goal is to get the information in the EHR and meeting whatever particular criterion is in there. So, for example, that information collected out of band is imported and reconciled meeting those specific functionality requirements. So, one way of saying "yes."

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

Sure. Any other comments on the pre-visit scenario, the visit scenario and the post visit materials on 6, 7, 8?

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

Cris, I'm thinking that we're going to have to give folks a chance to read them.

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

Yeah, fair point, so I'm wondering, Liz if it might make sense for us to just review quickly next steps then we take a bash at that so we can get some time for public comment and get prepared for our next meeting.

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

I think so.

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

So, I think we said we were looking…we were asking for the ONC team to do annotations to the medication scenarios we walked through last time as well as, you know, whatever came out of our discussion about outpatient today, to just improve the scenario document and then when we meet again the next time we would walk through those annotated, you know, edited versions to those documents, these test scenarios and essentially, you know, approve them. And then we would move to the outpatient, I'm sorry inpatient scenario and then an emergency department scenario. Does that sound like a correct summary of our agenda, Liz and ONC team?

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

It does, it does.

Carol Bean – Office of the National Coordinator – Director, Certification and Testing

I have a question, this is Carol, would it be helpful to have those revisions, the revised documents in advance of the call or do you want to do it on the fly in the call?

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

Yeah.

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

Well, that's kind of where we had talked about potentially doing a little bit of subgroups where…and, you know, Cris we could actually take a meeting and just do a subgroup or everybody is invited, where we really dive in and then we have a discussion, because we're sort of trying to review and amend, and then review again all at the same time and it's hard to get our arms around it.

Carol Bean – Office of the National Coordinator – Director, Certification and Testing

Right, and I think actually, if I can just…I think that there might have been a little bit of confusion as to who was picking…where the ball was when we ended the last conversation, so I think that we were expecting to see or hear a little more from the group, which may be why or which explains why we did not prepare things in advance of this. So, I think the expectations are clearer now, but where I'm asking, at this point, is when do you want to see these revisions so that we could perhaps have another, you know, a cycle at least the asynchronous review prior to the active discussion?

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

So, my suggestion would be, you know, if we could turn them around quickly while it's still fresh in people's minds that would be helpful. This is an idea to be amended, just the proposal is that I think some of these might make sense to do as a little bit of either a pre-read for the whole group where we walk through them and then we find a particular issue that we want to assign to some subgroup or individuals and there maybe some instances where, you know, we can see the scenario, let's say the, you know, ED one to be looked at next and to identify, gosh we really want to assign, you know, a subgroup to look at this first before it even comes to the big group. It feels like the inpatient, outpatient and medication ones have been broad and general enough that it has made sense for the whole group to look at them. Carol and Liz, what do you think?

Carol Bean – Office of the National Coordinator – Director, Certification and Testing

I'd agree.

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

I think that will work.

Joe Heyman – Whittier IPA

This is Joe, I just want to say I've just been reading this scenario and I've got a few things that don't seem consistent with reality.

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

Yeah, that's what…Cris, that's what I was thinking is if we could somehow before the meeting get that kind of input documented then when we come to the meeting we're discussing input, does not mean in any form or fashion that we wouldn't get additional input or response to the input that we had.

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

Right.

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

But instead means that we wouldn't be coming from a blank page, you know what I mean?

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

Got it, so scenarios goes out a week in advance, we ask people to read them, think through them, make comments.

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

Correct.

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

And prepare to come here, sort of informed as opposed to first read, that makes total sense to me.

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

Yeah.

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

Liz, I think we probably want to have the opportunity to call an audible that if one of these things is, you know, we just know is really complicated and we want to ask specific individuals to get together and discuss in advance because of the detail.

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

Right.

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

Or difficult, you know, we may want to do that.

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

I agree.

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

Okay.

Joe Heyman – Whittier IPA

So, in the meantime we all have this particular document so maybe we could just send in information about this particular document since we already have it?

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

Correct and the inpatient scenario that we did not get to today.

Joe Heyman – Whittier IPA

Okay.

Chris Brancato – Health and Human Services – Office of the National Coordinator for Health Information Technology

Cris, this is Chris Brancato, we will be providing the ED scenario as requested.

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

Great.

Joe Heyman – Whittier IPA

Where should we send this information, just to the usual address?

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

Yeah, hey, that's something to ask MacKenzie, I mean, I know that we send this out to this huge mailing list, is that what we need to do or can we limit at least some of this kind of conversation among this actual group? Is that permissible and then as we get more results we can involve a bigger group?

MacKenzie Robertson – Office of the National Coordinator

So, I would suggest if there is stuff that you want to work on behind the scenes off line you can just do that over e-mail amongst yourselves, I would include Scott if he is going to be the one…

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

Absolutely.

MacKenzie Robertson – Office of the National Coordinator

That is going to be collecting all the comments.

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

Yeah and I would say…

MacKenzie Robertson – Office of the National Coordinator

And then if we're going to be bringing the comments onto the next Workgroup call we will just have that finalized version that discuss all the comments combined into one document distributed.

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

And do we have a list of Cris and Scott and yourself, and just the Implementation Workgroup members?

MacKenzie Robertson – Office of the National Coordinator

There is an e-mail distribution list of just the Workgroup members.

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

Great.

MacKenzie Robertson – Office of the National Coordinator

If you want to…

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

Would you just…Cris could we have that…we'll just get that distributed is that okay?

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

Yeah, if you could send out an e-mail with that distribution list on it for instance just with some sort of message that says for, you know, for comments on the scenarios then people can simply reply to that e-mail and, you know, add attachments if they want to, that would be great.

Joe Heyman – Whittier IPA

I agree, that would be great.

MacKenzie Robertson – Office of the National Coordinator

Okay.

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

Super. So, we just have a few minutes left I want to be respectful of time. It sounds like we've got a go forward. When is our next meeting, MacKenzie?

MacKenzie Robertson – Office of the National Coordinator

Our next call is scheduled for August 2nd and then we have weekly calls after that, so there is a bit of a gap between now and the next meeting. Do you want to leave it as is or do you think it would be worth having another call in between there? We have a call on August 2nd, August 9th, August 13th and the 23rd and September 5th.

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

I would add another one, this is Scott.

MacKenzie Robertson – Office of the National Coordinator

You would want another one?

Scott Purnell-Saunders – U.S. Department of Health and Human Services – Program Analyst

Yeah, because this gives us time, I mean if we're looking at reviewing the information for the Medicare management as well as the outpatient scenario and the inpatient, and the ED before August 2nd we need to kind of have some internal conversations about that before that.

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

Actually, my calendar has a meeting on July 25th at 10:00 Central, is that not…sometimes my outlook is goofed, but is that one not correct?

Carol Bean – Office of the National Coordinator – Director, Certification and Testing

Actually, I've got one on the 25th too.

Joe Heyman – Whittier IPA

I have that list also.

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

I do too.

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

Okay, so it sounds like what we want we to do is to get back out annotated red line versions of the med management one any commentary that is collectable based on our discussion today on outpatient, you know, the inpatient scenarios, well and then if the ED scenario is available to try and distribute that over the next couple of days or the beginning of next week with the instruction to get everybody to read it the week of the, you know, the end of the week of the 16th, the beginning of the week of the 23rd and to get comments back to this distribution list that Chris and Scott will pick up prior to the meeting on the 25th. So, when we come to the meeting on the 25th we'll have comments collected into one document. Is that fair?

Joe Heyman – Whittier IPA

Sounds good.

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

Sounds good.

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

Excellent, so if there's nothing else from Liz, I think we should ask MacKenzie to open us for public comment.

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

Agree.

MacKenzie Robertson – Office of the National Coordinator

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

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time.

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

All right, so thanks to everybody on the team, I think we're making progress, hopefully we've got a bunch of meetings lined up and we can accelerate through this. Thanks for everyone's patience and intelligence in trying to get our arms around this. Look forward to getting any written comments over the next two weeks and we'll see you all on the 25th.

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

Thanks everybody.

MacKenzie Robertson – Office of the National Coordinator

Thanks everyone.

Joe Heyman – Whittier IPA

Bye-bye everybody.

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

Bye-bye.

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

Thanks everyone.

Public Comment Received During the Meeting

1. Please ask the committee why these test scripts are referencing 2011 Edition criteria (170.302(c) for Patient Problem List) instead of 2014 Edition criteria (170.314(a)(5) for Problem List).
2. Advance Directives are for the Inpatient environment only. These test scripts must be apply the correct criteria for the environment under certification. Thanks.