

**Vocabulary Task Force
Draft Transcript
February 4, 2010**

Presentation

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Hello. This is Jamie Ferguson. I think we're going to wait just a couple more minutes for everybody to join.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay. Why don't I do a quick roll call now and see who's on?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Great.

Judy Sparrow – Office of the National Coordinator – Executive Director

I'm doing a roll call. Jamie Ferguson?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Betsy Humphreys?

Betsy Humphreys – National Library of Medicine – Deputy Director

I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Don Bechtel? Chris Brancato?

Chris Brancato – Deloitte – Manager, Health Information Technology

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Lisa Carnahan?

Lisa Carnahan – National Institute of Standards Technology – Chair

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Chris Chute? Bob Dolan? Greg Downing?

Gregory Downing – Office of the Secretary, HHS – Program Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Floyd Eisenberg? Doug Fridsma? Marjorie Greenberg?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Patricia Greim?

Patricia Greim – VA – Health System Specialist: Terminology

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Amy Gruber? John Halamka? Stan Huff? John Klimek? Claire McDonald? Marc Overhage? Marjorie Rowland?

Marjorie Rowland

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Dan Vreeman?

Daniel Vreeman – Regenstrief Institute – Research Scientist

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Walker? Andy Wiesenthal? Eric Strom is on for Nancy Orvis. Did I leave anybody off that list?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Nancy Orvis is on the call.

Judy Sparrow – Office of the National Coordinator – Executive Director

Good. Okay. Anybody else? All right. Jamie and Betsy are on the line. This is not in the public, but workgroup members, please remember to identify yourselves when speaking. Jamie?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Great. Judy, thanks very much. Today we really wanted to focus on a discussion about comments on the IFR and the NPRM, primarily on the IFR, that we wanted to bring up to the standards committee in the upcoming standards committee meeting. And so Betsy very kindly sent out a document with a few things that we had talked about previously. Betsy, I'm wondering if you would mind me putting you on the spot to walk us through those points.

Betsy Humphreys – National Library of Medicine – Deputy Director

No, I don't mind. I'm going to test something because I'm using the phone and the mute button. The mute light doesn't work, so I'm going to try something and see if you can hear me or not. If not, I'll pick up the phone. Do you hear me?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

Good. Thank you.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Betsy, before you start, I heard a couple more people beep on. Can I ask who has joined?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Floyd Eisenberg.

Donna Pickett – NCHS – Medical Classification Administrator

Donna Pickett.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thank you. Who else just joined?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Chris Chute.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thank you very much. Betsy, go ahead.

Betsy Humphreys – National Library of Medicine – Deputy Director

I had sent this out last night. Sorry for the just in time distribution. Basically when we discussed the requirements, we reviewed things, particularly in Table 2A in the IFR. There were a number of comments made by the group, and I tried to summarize them. Doug gave us the ... in terms of the IFR, we might be able to recommend an expansion for 2011, but we would not be able to recommend any additions for that, or not additions would be made.

However, in terms of what we came up with, my notes said that the principal comments that came up in the room were in terms of the stage one requirements, which are those for 2011. There was an apparent discrepancy between the NPRM and the interim final rule in that some of the quality measurement requirements in the NPRM at least implied use in 2011 of standards that are not included in the IFR's 2011 requirements. Floyd was the one that brought this up in his presentation. And, as I recall, one of the issues related to vital signs where, in terms of the quality measurements, the way you would identify some of these things are through LOINC codes. And, in fact, there is no standard required for vital signs in the stage one requirements for 2011.

The other thing, which appeared to be an error in the stage one requirements was the fact that HIPAA code sets required by law for the purpose of describing procedures have an ID, meaning that is or defined as either ICD-9-CM or CPT-4, and it was brought up that the HIPAA code sets or procedures include HCPCS. Then we had a discussion about ... that if HCPCS were allowed for medications or drug information, this would not be a good thing at all. But in fact, the discussion of the use of the HIPAA code sets was against this category of procedures, and they were not mentioned in the medication list or e-prescribing part, so I think, therefore, we don't necessarily have to – I don't think that the rule was actually recommending their use, which is probably a good thing.

Then there were a number of things that related to comments that related to the stage two requirements, and in many cases, the issue was whether some of these things should be used for pieces of the record in stage two or whether, in a number of these cases, it would be possible to use subsets of the major clinical vocabularies and coding systems ... SNOMED, LOINC, and I guess SNOMED LOINC in these cases. Then there was the issue of whether a UNII provided the correct level of granularity for medication

allergies. I may very well have missed other important points of the discussion, but that's what my notes told us we had brought up specifically related to the IFR.

Now in the case of this discrepancy between or possible discrepancy between the NPRM and the IFR around quality measurement requirements versus standards in the IFR, I think our discussion was that we would have to submit that comment or a comment about this would have to be submitted both on the NPRM side and on the IFR side.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, Betsy. Thank you very much. Can I just ask? I've heard a few other folks beep on during this first part. Can I ask who else has joined?

Clem McDonald – Regenstrief – Director & Research Scientist

Clem McDonald.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

Andy Wiesenthal.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Stan Huff.

Bob Dolan – HL-7 – Chair Elect

Bob Dolan.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thank you all very much. Thanks, Betsy. There are, just looking at my own notes, as you were reading through that, and there are a couple of other things you mentioned I wanted to expand on a little bit. One other thing that you didn't mention that I think we discussed, which was also the need for cross maps, particularly for the RxNorm allowable vocabulary, those things that are mapped to RxNorm that are allowable in stage one, moving to RxNorm in stage two. The fact that cross maps have to be licensed from the source of the propriety vocabularies. We talked about possibly making the recommendation that if those things are allowed now, if those are adopted standards now, and moving to RxNorm, that those cross maps should be in fact paid for by HHS. That's one thing.

Bob Dolan – HL-7 – Chair Elect

Jamie?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

Bob Dolan – HL-7 – Chair Elect

It's Bob. Can I ask Betsy a question about one of her comments?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Please.

Bob Dolan – HL-7 – Chair Elect

I think I had a similar understanding that I had discussed with Floyd, Betsy, and I just wanted to make sure that this was the same thing. The fact that the IFR and the NPRM talked about certain terminologies are required initially, and then other terminologies are optional now and may become required down the

road, whereas if we look at some of the value sets developed for quality measures within HITSP, for instance, they don't necessarily adhere to those. And so there's a disjoint set of recommendations in the IFR and the NPRM saying, on the one hand, these are the vocabularies you must use now, and these other ones are optional. But you must also adhere to all of these quality measures, which, by the way, only define SNOMED value sets currently.

Betsy Humphreys – National Library of Medicine – Deputy Director

Floyd could describe this better than I could, but I think there was the issue that if you looked at when certain types of reporting of quality measures were required first to be asserted that you could do it, and then to actually do it, that essentially you were going to have to report certain quality measures and the likely way to do that involves standards that are not listed there. Floyd, you're on the phone, aren't you? Why don't you explain this?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes. I think that's really the thought was getting at is if the measures are stating standards that aren't in the IFR for 2011, even though you're only reporting by attestation in your summary, you're still looking at the measure at the implementation site, trying to understand how do I go from the SNOMED list to what I have in my EHR. There is a bit of a disconnect. If there's also an ICD-9 list, if we're talking about, say, problems or conditions, then you could still report because you know that.

But the one way it can be done and, Betsy, please correct me if I'm wrong or anyone else on the call who is more versed in this than I am. I think there is a way to develop an ICD-9 set from the SNOMED list, but not vice versa. It doesn't go the other way so that you could use the SNOMED list to implement. So you can answer is that's correct.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that if you have SNOMED list, you could develop a corresponding ICD-9-CM list. In order to do it, you might generalize what you were retrieving beyond. You know, you might then have to use some other method of isolating within that larger set, the piece that you actually wanted.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right, so the measure developers not having – if they haven't done that effort to do the isolation, then the reporting is going to be less consistent.

Betsy Humphreys – National Library of Medicine – Deputy Director

I would believe that to be true, and we were talking about the emerge approach and Chris is involved in that project and knows more than I. But I think that the notion that you might be able to define a universe using ICD-9-CM codes, but then to actually, in some cases, potentially to get to the set of patients that you really wanted, you might have to then do some sort of processing against the clinical text.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Or, additionally, medications and labs.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. Right. Add something into the definition.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

One more answer to Bob's question is, as other measures are being retooled for this meaningful use effort, the measure developers are creating ICD-9 sets and SNOMED sets. It's the 16 in the technical note that would be problematic, as you indicated.

Bob Dolan – HL-7 – Chair Elect

Right.

M

Could you just explain that a little bit further? For the one side, I heard that they're all defined only in SNOMED so that it created the problem you just said. Then I heard you just say that they just defined it in both forms. Is that – so is there ... corner, what's the little corner?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I'm sorry. The technical notes that HITSP put out includes 16 measures that CMS handed to them to retool, and in that retooling process, that all started prior to the ARRA legislation and prior to the standards committee's existence, and then so they were taking the HITSP recommendation for problem lists, and the recommendation with SNOMED. So they did all their coding only in the vocabulary selected by HITSP for harmonization in those 16 measures and all the value sets they created.

NQF was handed a list of 112 additional measures, all of which are basically in the NPRM, and asked to have them retooled. Not all will be done by April, but a significant number will, and as we are having those measure developers retool them because we're aware of more of what's in the IFR, or we suspected, we are having them, if they are looking for a problem concept, create an ICD-9 list, and also create a SNOMED list. Not mapping one to another, but creating ... so there will be both value sets that can be used, and the measure developers will have selected and know what answers they'll be getting.

M

Thank you.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

Jamie, this is Andy. I just wanted to interject for a second, and I realize the practical value of doing that, logically how it's going to proceed, but what we'll have at the end of the day with measure sets is we'll have Macintosh apples and Golden Delicious because of the problem that, Bob, you were referring to just a few moments ago. There's not an identity between SNOMED and ICD-9-CM code. Where there's not, the population defined will be slightly different. It's just unavoidable.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. Exactly.

M

Yes, and I think, as we've looked at that at NQF, we understand there's going to be a transition period where that is a fact.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Is there anything else on this topic, or would it be appropriate, Floyd, for you do draft up a comment expanding on what Betsy put out for our vocabulary taskforce comments to the standards committee coming up?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I'm happy to draft that and send it to the group. Sure.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Great. Thank you. Betsy, if I can switch gears then, one of the things that you mentioned was the suitability of UNII for medication allergies, and this is something that we did discuss previously where we talked about the fact that medication allergies basically are not captured at the ingredient level. They're captured at the clinical drug level, and that it could be a burden, and ... issues that getting medication allergies at the ingredient level. So I'm wondering what sort of comment do we want to make on that. Our previous recommendation out of the standards committee was in fact use UNII for the non-drug allergies and to use RxNorm for the medication allergies.

Betsy Humphreys – National Library of Medicine – Deputy Director

I will certainly be happy to write up whichever the clinical and practical opinions of the group think is the way to go for this. My understanding is the same as yours, and I also assume that there can be, in a clinical environment, a desire to do both things. That is, avoid giving the patient a drug that includes an ingredient that he or she might be allergic to, even though it's different clinical drugs.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. As opposed to essentially requiring testing to determine allergies to ingredients and the ... ingredients in common drugs. So I wonder if perhaps we would recommend then that an alternative standard for drug allergies would be RxNorm. Does that sound acceptable to folks?

M

Jamie, can I ask a question? Are you saying exclusively, or are you saying in addition to?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I'm saying in addition to.

M

Okay.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

The way the IFR right now says that UNII exclusively must be used for medication allergies.

M

That's recording the fact of an allergy? Is that what they--?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

M

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

Let me just say, I believe everyone on the call probably knows this, but obviously if you record the allergy at the RxNorm level, the clinical drug level, then you have the information about the ingredients in the clinical drug and could go from there. But, of course, you might not actually know which ingredient the person was allergic to.

Clem McDonald – Regenstrief – Director & Research Scientist

I think there are two other levels of complexity. One is that very often allergies are reported by class, you know, penicillin allergies meaning a family of penicillins or a family of tetracyclines, so that's....

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

This is Nancy Orvis. Having worked on the tie paper on allergies, you're right, Clem. I want to make sure at this point that the UNII code includes the – we had all of the non-medication allergies that could have been at the ingredient level, but it also was going to be foods, environmentals such as cat dander and anything else. But I believe if you are using – if many healthcare systems are using something like a FirstDatabank or MicroMedics, they have some selected things in their list for allergies that are related to medication ingredients. It just depends on what they're using.

All I'm saying is some can record it at the ingredient level because that may be, you know, I'm allergic to red dye number two. That's where you get an ingredient kind of allergy.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

...talking about drug allergies specifically, right?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Yes, but you get that through your MicroMedics or your FirstDatabank or your knowledge vendors in the pharmacy area generally.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Yes. This is Chris. We actually did a paper in ... on how well RxNorm maps to class A, either within RxNorm or NDFRT, and the short answer is it's not very pretty.

M

What version did you use?

M

Chris, that's a little outdated. We've done some double-checking here, and it's better than that. But the real question still is, do we understand the problems base well enough? Shouldn't we get some of the NCPDP and pharmacy knowledge vendors in? I think we could create something that's not going to work. I mean, we could make it work with RxNorm, but I just worry that there's a lot of simplifying assumptions.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I'm going back to, I'm also going back to the sort of overriding principle that we can constrain, modify, or take away requirements in the IFR. We can't add.

M

But this is stage two. Remember, this is stage two, so this is just an indication. There is nothing in this space for stage one, and this is just an indication, candidate standards for stage two. So it seems to me, we could develop a set of comments that would, in effect, point out that there are various levels of recording of drug allergy information and multiple levels may be useful for different purposes or patients or whatever we'd want to say. But I think that these are only candidate standards, so we can certainly highlight what we think is the best way forward and say we ought to work on this problem between now and 2013.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

This was something, as was suggested....

M

Or next year.

M

Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

We can bring in others to discuss.

M

Yes. We can get the latest data from the DoD VA allergy alert work too because medication allergy alerts.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that, therefore, the base of our comment would just be that, in essence, the ingredient level may not be the best or only.

M

Well, I think you need it, but you also....

Betsy Humphreys – National Library of Medicine – Deputy Director

The other thing.

Clem McDonald – Regenstrief – Director & Research Scientist

Yes. The common classes are....

M

You need the drug classes, absolutely. I agree, Clem. We've already shown that.

Betsy Humphreys – National Library of Medicine – Deputy Director

And, of course, the other thing is that if somebody knows that someone is allergic to a specific drug, then it would seem to me there's not a harm in ... specific clinical drug, there's not a harm in recording that either.

M

Right. You can climb from that up to the class too, yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes.

M

The question is, are we requiring that they have to have it at the most discrete level? Are we just saying that if you have it, use this?

Betsy Humphreys – National Library of Medicine – Deputy Director

It's really not clear what the requirement is because this is put in that. It's in the....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, I agree. It's not....

M

Let me make a recommendation, Nancy, because we've been doing this for three, four years between DoD, VA in terms of triggering a medication alert. The big question is, the first time you do these exchanges, everybody is going to have their historical files, whether they're good or bad. It's going to be whatever has been put in that EHR related to allergies and whatever proprietary thing it is. You can say that when you are going to map up to do exchange, you could even tell them to just provide a list. But you will say that if you have this in that list, and you want to provide the ingredient, you can show the ingredient through this or map it up to the ... level that you can find. Maybe there are some words we need to refine that to.

The problem is that sometimes you just have this historical allergy file on patients, and what do you want to exchange first? You want to exchange that and just say, I don't know whether this is going to compute or not, but this is everything that's been said on this patient at one point, you know, over the last five years.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I think all of that is detailed work. This is Stan, by the way.

M

Yes.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

We need to do, I think, in this comment, which is where I'm trying to focus, really what we need to say is that in addition to being able to capture ingredients, we need to be able to capture the clinical drug or the clinical drug class, and there might be something else that we've left off the list that we also need to be able to capture.

M

Or the ingredient, right.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Well, we started off with the ingredient.

M

Yes.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

The ... is the ingredient, so I think that's what we need to say here. Then we need to do further analysis. RxNorm would probably work great for the clinical drug level specification. We need to say what would be the name for drug categories if you're talking about just saying penicillins or it could mean anything that was penicillin.

M

NDFRT was supposed to be supplying drug classes that were related to allergens.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. I mean, at this level, I think we just need to – the point is that you can't make a workable system with just the UNII's.

M

No.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Not even in a perfect universe, I don't think, because you just don't know the ingredient. What you know is they took this pill, and they had this – well, there are all kinds ... but what you really know, but in the best case, you just know that they took this pill, and you don't know whether it's an active ingredient or one of the "inactive" ingredients that caused the reaction even.

M

Stan, I'd like to refine that. I agree, we should probably just say at this level that the ingredient and the orderable drug and the class, and that UNIs are being considered because when we expand our recommendations to be more than just medication allergies, because it will be the source of all other kinds of ingredients that are even non-medicinal ingredients, something like that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That sounds like a plan.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I'm fine with that. Now could somebody say more about the other comment that's in this same section that SNOMED CT should be mentioned for some categories of lab test results? Could you say more specifics about what that was intended to mean?

Betsy Humphreys – National Library of Medicine – Deputy Director

Can you hear me?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

Stan, this is Betsy. My mute button is not working well, so I can't tell whether it's on or off. It was just the notion of if in fact you were testing for, you know, test where the result would be organisms and so forth.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. I was going to say....

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

...more specific about using SNOMED as the value of those.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. Right.

M

I think it's ... finding codes. It might be easier, clearer to say it that way.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. Fine.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. Yes, that's a good clarification.

M

And organisms is really kind of dead center, well the more important ones too.

Bob Dolan – HL-7 – Chair Elect

Can I ask a naïve question? Would all of the people on the phone that I admire and respect so much, give me one naïve question, okay. I get confused when I look at SNOMED on the one hand, and I look at NDFRT, RxNorm, and UNII on the other hand, particularly when I think in terms of doing inferencing for drug allergy decision support. And my own belief is that ultimately these things should at least be logically or virtually integrated so that we have a terminology with a single set of APIs and terminology services. You know, having all of these different terminologies with their own different look and feel and shape and access method, I find confusing.

M

Coming soon.

Chris Brancato – Deloitte – Manager, Health Information Technology

Well, I mean, this is Chris....

M

Hidden Valley.

Chris Brancato – Deloitte – Manager, Health Information Technology

...this is Chris, Bob, and I agree that their terminology is in different shapes and sizes. But as you know, there's been a large community working on common terminology services to, from a user perspective, hide all that diversity. I think it's been demonstrated that can be done fairly successfully.

M

I agree with Chris' comment, and two things: First, that SNOMED CT drugs are one of the linked in vocabularies in RxNorm, so there is that connection. And the issue of how the connections between SNOMED CT and LOINC will be specified and how they will be distributed perhaps in more integratable ways in the future is a subject of active work, maybe good announcements coming relatively soon in that area.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. It sounds like everyone believes that while these are, I guess, Chris, what you refer to as federated terminologies, from the perspective of the implementer over time, they're going to look more and more, at least from a virtual perspective, as though they're integrated terminologies with consistent decision support. And we're already on track for that, so that there's nothing that folks feel we need to say in response here.

Bob Dolan – HL-7 – Chair Elect

I don't think there's clarity about the precise infrastructure that would be brought to bear to achieve that vision. There are candidates, but I don't think it's been – it would be an overstatement to say that the problems are solved.

M

I think you'll have time, Bob, to have that happen, considering that really none of the standards are being used very well. I mean, you don't have to say the multiplicity now. It's just that right now everybody use their local codes, so we'll have time enough, I think, to get to unification. We have to at least get some of the standards being used at all anywhere.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Switching gears once again then, one of the other things to amplify on a point that Betsy had made about UCUM, and it's another one of the phase two candidate standards. One of our previous discussion points was about the use of UCUM for lab results. And one of the complaints from labs is that FDA has not required UCUM in devices and a lot of the test ... equipment doesn't produce UCUM units, and so I think labs feel there are some problems in adding a UCUM version of the units of measure in the results that they supply in response to the order. Is there anything we want to say about that kind of coordination or broader coordination on UCUM?

Clem McDonald – Regenstrief – Director & Research Scientist

This is Clem. I've been working with ... American Clinical Laboratory Association on a number of things right now in terms of order sets, you know, the common orders, and have made a lot of progress.... I think that partly they don't understand it. I don't see what the alternative is to UCUM. Either we just send text junk because it's not instead of that, it's in addition to it that you're going to have something that's formal, and you know ... and can compute them. Actually, I think it is going to show up in the FDA's STL for instruments.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

This is Stan. I would just add a comment. I think that's exactly right. I think, when people ask questions, you say, what would you propose to use instead? I think UCUM is the best thing to use, and you have to use UCUM. I think, what we need to do, and I'm not even sure in this process ... how you do this, but there are implications of using UCUM that where a common practice is not supported by UCUM essentially. You can describe it. You can do other things. But, I mean, people just commonly send out things that say, you know, beats per minute. Well, by standard UCUM stuff, you don't say beats because just per minute is the real per unit, and so there needs to be some description to say how is common and useful behavior that people are doing now supported if you're using UCUM.

We probably need to have some discussion amongst us about the right way to do that. I think that's where people fall into problems is they start implementing. They go, well, we've got this thing. Yes, we can put a bracketed text thing in here that says beats, but that's not esthetically what people want to see, so how do I make a workable system that looks how I want it to look, but is using UCUM as the real formalization, the real formalism underneath there? And I think you have to use UCUM, but we could do everybody a service if we got together and, people that have been using UCUM say, here's a standard way to approach this so that we have a uniformity in how UCUM is used and that solve some of those practical issues.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Is there any comment that we want to make on this at all at this point, or is this just something that we want to essentially put on our agenda for future discussion with others?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

This is Nancy Orvis. Is it our question that we're not sure where this serves with FDA, or do we want to say that we want to go work with FDA and make them require UCUM, and that that's the work we're going to do?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I like that, but it's outside the scope of an IFR comment.

M

It would be, I mean, we just translated about 14,000 string units in LOINC, which includes beats per minute into UCUM, and all we really need to do is strip off ... brackets, and you can have a nice, pretty version, and a uniform UCUM version. We could do that next week ... time to discuss it. People could look at them and see what they think. I think it's less of a problem for most testing, and they mostly look like regular test results, milligram per deciliter, grams per liter. They have the same look.

M

They don't when you go to English units ... pounds and those are really ugly.

M

You're right. You're right. Yes.

M

It's solvable. I'm not saying ... it's easily solvable, and we just need to do that. That's exactly what we need to do is make a table and say, if you're using this, this is how it looks in the message, and this is how you can show it to your users.

M

Yes, okay.

M

The only reason I mentioned that is that it helps us. I think our general comment needs to be predicated on the fact that we are going to make sure, through many of our other activities, that we put that on an action item or priority list to address.

M

But to get that back to your question, I'm not sure, Jamie, that we would say anything as a response to the NPRM IFR about....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So this is a followup item for us in taskforce meetings, but it's not part of our IFR comments.

M

That's what I think.

M

Agree.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

One of the other things that, again, Betsy had mentioned and was in her documents is the candidate standards for stage two for vital signs, and what we want to say and what we want to recommend there. I think we were in agreement that CDA templates does not sound right.

M

You mean as a standard?

M

Not as a vocabulary standard.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

M

Well, HITSP had taken a position on it in CA.

M

What does it say?

Clem McDonald – Regenstrief – Director & Research Scientist

It says LOINC, and I wasn't even at that meeting.

M

Come on. You're always present.

M

Can you repeat which one that was? I'm sorry. I was....

Clem McDonald – Regenstrief – Director & Research Scientist

It's LOINC. You can find it in CA.

M

What's the category?

M

Vital signs.

M

Vitals.

M

Yes. Actually, HITSP did say LOINC and Clem wasn't there.

Clem McDonald – Regenstrief – Director & Research Scientist

Thank you. Thank you.

M

Obviously I'm bias, and I like LOINC there, but I wasn't there either, but I like that choice.

Clem McDonald – Regenstrief – Director & Research Scientist

Can I comment?

M

This reminds me, Clem, of the discussion we had with Jim Case in Phoenix where....

Clem McDonald – Regenstrief – Director & Research Scientist

Yes. You agreed to that, right?

M

Yes. I agreed to that, and I said, boy, I wish I didn't have to care. My hope is that between the LOINC committee and the SNOMED committee, you guys free me and free the implementers from the need to

have to map where there's similar concepts in SNOMED and LOINC, so picking one is great, but there are obviously lots of other scenarios where people are going to be receiving SNOMED codes as well. Picking one, you know, that solves part of the problem because if everyone had to use the same thing, then there's no need to map. But we still have the situation where there's both, and we have to figure out how.... I know that there's a lot of great work going on between LOINC and SNOMED now in the lab domain, and that's why I'm quite happy to go along with your recommendation here. I just thought it was worth saying that again. Since there's still silence on the line, and people don't know how to react, I'll just keep blabbering a minute.

This LOINC/SNOMED issue, to me, is reminiscent of the CCR/CDA issue where ultimately it wasn't a matter of picking one. It was a matter of HL-7 and ASTM coming together to come up with the CCD standard. That's the kind of thing that I see happening with lab LOINC and SNOMED. I think it's just a great, great thing. And, if anything, I'd like to see it continue to happen even through clinical LOINC.

M

I for one agree with all that. It just seems like it takes a long time to get all of these sorts of formal things in place to do that.

M

Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. What other comments do we want to make?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Jamie, this is Nancy. I understand, I think, from the direction for the IFR that we're not supposed to comment on deletions from the measures in the IFR.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Is that correct? Deletion of the advanced directives came up. But should the HIT standards committee make comments on the NPRM?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

They can.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Because it makes sense that we've got, I mean, if there were any of the measures that were deleted to changed, should the committee make any comments across that?

M

Nancy, were the deleted the fact that you should ask to advance directives?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

The way I looked through this the first time, it says they deleted the requirement to show that you could do advanced directives.

M

Okay. It may have had something to do with the political backwash about that.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Okay.

M

I think it's important. We probably should ask.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

There are a couple other things—I can get my list out—that were deleted or changed by CMS, but I just didn't know if that was something we wanted to get back to and say anything like we understand it's been deleted, but we still think the standards for this are rigorous enough.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, so I don't disagree with the possibility that out of the standards committee. I think, right now, just for this call, we're focusing really on the controlled vocabulary standards and comments related to those.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

Fine.

M

Individuals can comment too.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Absolutely.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief

I just didn't know if there was any opinion, and I don't think that we have to have an opinion on those. I just wondered if there was any feeling across the committee itself that there was surprise that certain ones we thought we had put vocabularies or standards to were now deleted. Okay. So we'll drop that or we can think about it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thanks. Anything else that are vocabulary related comments that we want to make about particularly the IFR, or about the NPRM? Okay. Hearing nothing, the one other question that I wanted to have folks consider for this call is we agreed that in our next meeting, we're going to really focus on rules of the road and governance, as I think Andy Wiesenthal had proposed in our face-to-face. The question, I think, in terms of structuring that meeting is whether we want to invite people who are not members of the taskforce or the standards or policy committee or basically who else do you want there. This is going to be a public meeting. Do we want to have others? Do we want to specifically invite others to that is the question I wanted to raise here today.

M

I know that there are some other people who are interested, for instance, Lee Min Lau and Shaun Shakib at 3M would be very interested in participating in these kinds of meetings, and I suspect that there are other vendors, other academic centers that would also be interested.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd. I know that folks at CDISC, I realize they're into more research area, but are very interested and have been working in this area.

M

In regards to governance, what's happened or the current status on the SCO, the Standards Coordinating Organization? Would that be for governance? Would they want...?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I don't disagree. We could certainly consider both SCO and others that have been mentioned for inclusion. Let's start, I guess, with the 3M. How do folks feel about inviting representatives from 3M?

M

Sure.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And also from the SCO, any disagreement there? Okay. I heard mention of other vendors. Who else?

M

It wasn't a vendor. It was CDISC, who has been very, very active in clinical instrumentation, obviously with a focus on how it's used in research. But, nevertheless, a lot of attention on data element formation, vocabulary binding, and I think Micky Kush would be a good person to consider.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. 3M, CDISC, and the Standards Charter Organization. I think it might have been Stan who said that other vendors would be interested.

M

There are a whole bunch of drug knowledge vendors, and I don't know whether that's relevant, but they think about these things, you know, the ... they were named earlier.

M

Yes. FirstDatabank, MediStan and MicroMedics.

M

But governance is a big subject. It's like everything under the sun, so where's the focus of the governance questions, or are we going to find them during this meeting?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think really we are going to find them at this meeting, but we talked about the processes for producing and contributing to value sets, managing them, disseminating them, and so forth, as well as rules for the subsets, the convenience subsets, both those based on....

M

So the focus is really on the governance of value sets and subsets?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think that's it primarily.

M

No, that's very helpful.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think, cross maps....

M

Coordinating across use cases, governance across intersecting use cases.

M

I mean, I think we have to be realistic about what one can accomplish in real life.

M

Or in one meeting.

M

Yes.

M

I agree, but my other question on the governance was, that was one. We can keep it narrower, but we still have to figure out how is the HIT standards committee or what role or whatever we have about coordinating interplay among SDOs, don't you think?

M

That's an eternal quest.

M

And that's why we had HITSP. That's why we had HITSP before, the issue of the SDO. What would be saying is asking for recommendations on what would the industry think of sanity might be good.

M

That's a very open-ended question.

M

Well, true, but in the context of vocabulary sets. Maybe we could narrow that down to say what, because I would be interested in hearing who would they be willing to listen to or ask to arbitrate. Do they want to see something like a HITSP continue as an arbitration body depending on the use case?

M

How well has it worked?

M

What does everybody think? Jamie?

M

I think we need something like HITSP, maybe not as an arbitrary, just to get the specifics down. That's a different question.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

...narrow the scope, and I think what we talked about thus far is really governance around value sets, subsets, cross maps and, as Nancy said, coordination across use cases.

M

That's a pretty big agenda.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

M

I guess, which is...?

M

...focus had been. I mean, we should stay with where the focus is, or we end up keep wishing and washing all over the place. So I wasn't on the last meeting, so I think you ought to stick with your guns.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

We have to start with value sets, I think, because value sets are the things that are ... regulation for these vocabularies. So I think the starting point, if we're going to focus on one thing, it would be value sets, I think. But I think....

M

Okay. Would that be the governance of the creation and the guarantee of the maintenance as governance?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

...maintenance, dissemination.

M

All right. That would make sense. You could talk about that. I think that would be good because some of that will raise up issues about continued funding....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Then the one other thing that we talked about really as a top priority for the starter sets, the frequency distribution based subsets as starter sets for implementation of the required vocabularies.

Betsy Humphreys – National Library of Medicine – Deputy Director

The other document that I sent you that I said wasn't for discussion at this meeting attempted to summarize the discussion that we had at the last meeting about those convenient subsets, sets, or starter sets, or whatever you want to call them.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. I just wanted to differentiate the frequency based starter sets from the specialty sets convenience subsets for ophthalmology orders, for example.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. Okay.

M

Back to your original question, the other group that comes to mind, Jamie, that I don't know if we have involved them yet. I guess I don't have it in my mind, everybody that's on this call even, but it seems like we would want somebody from NCI and all the work that's going on there with Frank Corvell and Denise Warzell and that whole ... representative from that group. They may not want to be involved, but I think it would be good to invite them.

M

What about CDC then on public health piece, or will NCI cover that?

M

They're not the same.

M

I understand.

M

...as an example....

M

I know that. I'm just saying.

M

...thought it would be helpful to have them at the table regarding governance.

M

Public health vocabularies.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That would, adding both NCI and CDC representatives would bring us up to a half a dozen other participants that we'd be bringing in, which sounds fine to me.

M

Are there other vendors that are an analogous in the vocabulary spaces and helping with implementations and so forth where it might be awkward to have 3M and not others?

M

Like Apalon?

M

Yes, there are.

M

Yes. There are three or four that....

M

Natural language....

M

There would be, there's Apalon, Health Language.

M

Yes, Health Language.

M

...knowledge objects. That's probably not inclusive of everybody even.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Well, do we want to....

Marjorie Greenberg – NCHS – Chief, C&PHDS

This is Marjorie. Excuse me. The point of view of other participants ... CDC, are you thinking about the informatics group in the new surveillance unit?

M

Are they now responsible for the THIN VAD stuff, Marjorie?

Marjorie Greenberg – NCHS – Chief, C&PHDS

I think so.

M

Okay. Well, that would have been the group that I would have thought.

M

The THIN group, right.

M

Would be most relevant, yes.

M

The THIN group.

Chris Brancato – Deloitte – Manager, Health Information Technology

This is Chris Brancato. I believe that's right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

We want to have, it sounds like, 3M and Apalon and who else?

M

Natural Language and Computing.

M

Then there's Intelligent Medical Objects.

M

And Health Language.

M

Yes. So, I mean, Jamie, I think maybe we need a little discussion here about how we would structure this meeting.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

M

Obviously we could, you know, it's going to be a public meeting, and we could alert all these people, but they might very well be interested. But then the issue is how are we going to organize it so...?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, it sounds like to me like it's kind of falling into two different panel discussions perhaps with different participants.

M

Yes. That sounds good.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Where we would have essentially research, public health, and I'm not sure, so I would put probably CDISC, NCI, CDC, THIN, possibly add the CSO in that group versus 3M, Apalon, Natural Language Processing and Health Language....

M

Well, you know, from my perspective, the people who were involved in serving up terminologies ... Chris, you would know this as well, but if we put them together, I mean, obviously NCI has experience in that space. THIN does to a certain extent. Another group that does for a particular purpose and has been very effective is the National Animal Health Network people.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think we're at time for this call, but...

M

Jamie, one other thought. Do we want to ask the Federal NIN CONNECT people to get any lessons learned on value sets and implementation issues, Commander Stephenson or Dave Riley?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

We could certainly consider that. Any objections from anybody?

M

...we may have more than one meeting ... but we can figure that out....

M

Then we can make a priority. Just a thought.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

It sounds like we can organize. We can plan to organize two panels for this meeting. Betsy, let's you and I discuss offline a proposal. We can shoot that out to the group by e-mail.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay?

Betsy Humphreys – National Library of Medicine – Deputy Director

All right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thank you very much, everybody. I really, truly, appreciate your time for this meeting, and see you online.

M

Thank you. Bye.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Thank you.