

Vocabulary Task Force
Draft Transcript
May 10, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good afternoon, everybody, and welcome to the Task Force on Vocabulary call. This is a Federal Advisory Committee so there will be opportunity at the end of the call for the public to make comment and also a reminder to task force members to please identify yourselves when speaking.

I'll do a quick roll call. Jamie Ferguson?

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

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Betsy Humphreys?

Betsy Humphreys – National Library of Medicine – Deputy Director

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Clem McDonald? Stuart Nelson?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Rallins? Stan Huff? Chris Chute? Marc Overhage? Daniel Vreeman? Floyd Eisenberg? Don Bechtel? Patti Greim?

Patricia Greim – VA – Health System Specialist, Terminology

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Tim Walker? Chris Brancato?

Chris Brancato – Deloitte – Manager, Health Information Technology

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Andy Wiesenthal? Bob Dolin? Ram Sriram?

Ram Sriram – NIST – Manufacturing Systems Integration Division

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

I think Lynn Gilbertson had Kay Morgan on for her. Is that correct, Kay? Are you there? I know she's joining. Marjorie Greenberg?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Terri Meredith, from Cerner; is that right?

Terri Meredith – Cerner Corporation – Director, Clinical Vocabularies

Yes. Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anybody off?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd Eisenberg. I joined a minute late.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thanks, Floyd. Okay. With that, I'll turn it over to Betsy, because Jamie has got his hands on the wheel.

Betsy Humphreys – National Library of Medicine – Deputy Director

And we want him to keep them there. Okay, we are following up, as you saw with the agenda that was distributed on the conversation, the topics dealing with last week. What I thought I would do very briefly before we started was to ask Stuart Nelson, who wasn't able to be on the call last week, to update us on a couple of items that are sort of directly relevant to what we were discussing in terms of near-term plans for RxNorm. Stuart, could you do that for us?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Certainly. With RxNorm, as you know, we are busy making releases on a regular basis. But as we're making enhancements, there are two important things that we're considering and are ready to implement. One is that we are aggregating groups of medications together when they have a similar dose form and the same ingredients. Thus, for example, something that you might refer to in RxTerms as "oral tetracyclines," meaning it could be a tablet, it could be a capsule, it could be an oral liquid, and so forth, are all going to be linked together in relationships as a group. This will enable us to essentially generate automatically out of these relationships the set of names that have been called "RxTerms" and keep them essentially in synchrony with our RxNorm releases. So that would be something that could facilitate electronic prescribing along the way so that if you wanted to generate a display in that way for the purposes of an e-prescribing system, that that would be available to you. So that is where we're creating the groups, and we're going to be incorporating that and coming up with a way to generate out of that the RxTerms names that would be associated. So that was one, I think, helpful addition that we would be making to the RxNorm production status.

The other is something that I've wanted to do for a long time but is a very hard thing to do, and that is to have an actual e-prescribing subset. Now, the uses of RxNorm include not only supporting this interoperability, but it's supporting interoperability over time so that even when a drug disappears from the market and is no longer available, we still want to keep a record of it in our full RxNorm releases of what it was, what was in it, and the relationships. That means that the full release of RxNorm will then have drugs in it that we are aware are not on the market anymore and should not be used in generating an electronic prescription because it's not on the market anymore.

The difficulty is knowing exactly what is on the market. Nobody really seems to know. However, from our variety of sources, we are getting indications, both at the product level and at the NDC level, of when products or NDCs are no longer available. Based on that data, we are going to begin making and releasing an e-prescribing subset. Now, this e-prescribing subset would not include any of the third-party sources, the copyrighted sources. It would just include the RxNorm names and codes as well as some of the other material, which is in the public domain, such as NDFRT. So we're about ready to make the first release of the e-prescribing subset, and I think that these two things will help make RxNorm even more useable for electronic prescribing.

Betsy Humphreys – National Library of Medicine – Deputy Director

Thank you very much, Stuart. Just for those of you who were on the call last week, the sort of integrated distribution of the RxTerms and with identifiers for the combinations that we were describing or the ability to pull out those sets, RxTerms plus RxNorm. I think that this actually means that the RxNorm distribution will go pretty far to address some of the issues that Chris Chute brought up last week, and we will have the e-prescribing subset described by Stuart in the June release. So it seems to me that that will give the opportunity for everyone to take a look at that to see and for ONC to weigh in as to whether we feel that that is the kind of thing that we may want to use in certification and testing, or not. But at least people will be able to see it and perhaps provide input on how it might be improved or changed if people believe it needs to be.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I want to say one thing. In certification and testing, it's often—it's kind of like the top 95% is the target it's aimed at. I think in this case, with RxNorm, our indication is that we're about five-ninths, 99.999% of all medications available in the United States, the problem being that we have medications that are not available in the United States and are not currently on the market. It's not that we don't have the ones that are on the market, it's that we have too many that aren't on the market. So it will be interesting to see how well we can do in getting down to just that which is on the market and that which is not on the market.

Betsy Humphreys – National Library of Medicine – Deputy Director

So the other question here in terms of the subset, Stuart, am I correct that at least initially you are talking about prescription drugs here?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Yes. We have lots and lots and lots of over-the-counter drugs, most of which I daresay that no physician would ever tell a patient to go and buy and take, but it's certainly possible that—there are some things that, for example, Allegra is a very good antihistamine that is going this year from prescription to over-the-counter. Something like that, the physician may not even be aware that it's going to over-the-counter and still want to prescribe it because that's what they want the patient to be taking.

Betsy Humphreys – National Library of Medicine – Deputy Director

So in this subset issue—this was something that I wondered about and wondered whether other people on the task force had input as to whether we would want to do, if we could, maybe get some sources—I don't know whether Kaiser might be a source, or whatever—of a set of over-the-counter drugs that likely would be important for e-prescribing and whether we have any good way or data sets that would help us identify those. So that's a real question.

Jamie, do you have any comment on that?

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

No, but I can certainly take that back and ask about that. But I don't know how such sets are handled for us in our different regional operations today. I'm going to have to look into that.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. Is there anyone else on the call who wants to comment on that issue?

Chris Brancato – Deloitte – Manager, Health Information Technology

Betsy, I'm aware of, at least in the state of Virginia, where physicians can e-prescribe drugs like Prilosec or other drugs that have transferred into the common market. But they do so so it shows up in the medical record, and insurance will pay for them.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah. That's the kind that we were thinking about. At any rate, it seems to me that we'll have to get some other input from people on whether this is a good issue. And whether there are some of these existing systems or so forth where we would have a good chance of honing in on a reasonable set of these things without— We know for the e-prescribing case, we don't want to bring in all the over-the-counters. A different story, perhaps, in ... patients that might want—be taking data from the patient or in a personal

health record situation where it might be beneficial for a person to record everything they are taking. This might, obviously, be a larger range of products than a physician is likely to prescribe.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I mean, there are, as has been pointed out, many other reasons that you would e-prescribe a medicine. Sometimes you might do it to simplify the patient's task. So they have four meds and they have four pieces of paper in the old days. Insurances are sometimes set up so that it's cheaper for the patient to get a prescription than to fill an over-the-counter med over-the-counter. I don't know how much effort it would take us, but I think organizations like ours that are doing e-prescribing could probably produce a list. It would probably take more work than anyone would want to go through trying to identify them. That might be the trouble is picking them out of all the others.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah. Well, I think we should think about how we might identify them, because one approach would be ... all the ones, and we know the subsets that are A question for the group now and for others that we might be talking to subsequently about this is how important it would be to have these. I would think it would be pretty important to have drugs, particularly those that recently crossed from one state to the other.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It's enormously dissatisfying not to have everything in the list that you can prescribe from, even if some of them you get a notice that says this is no longer on the market or this has become over-the-counter, or whatever.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Betsy, if I could say something about this?

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, of course.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I think the question is—we could put out an RxNorm name and code for every over-the-counter drug that we know about, and there's a lot of them.

Betsy Humphreys – National Library of Medicine – Deputy Director

I don't know that—

Stuart Nelson – NLM – Head, Medical Subject Headings Section

But, the other alternative would be as sources for RxNorm, if I get indications from six or seven different groups of what they consider relevant or the list of things that they consider important, I can put flags on those things and make sure that they get into an e-prescribing subset.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah. I think that we may—

Stuart Nelson – NLM – Head, Medical Subject Headings Section

So that might be a reasonable approach to take.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah. So I think that we may need to poll some people and figure out who can provide these data. We could start with some reasonable set, like we have done with other things, and try to get something that approximates what most people would be interested in.

The other issue—and we can take this up with ONC and with NIST, so forth in terms of the testing, would be—and in a few weeks they'll be able to look at the initial subsets that RxNorm is generating and see whether they think that's going to be a good basis for their testing and certification or not. The other issue

we wanted to deal with—I'm taking some of this a little bit out of order—would be Jim had brought up last week, and others, as well, how would we move to RxNorm for e-prescribing in the 2013 time frame or eventually the 2015. And—

M

Excuse me, Betsy. My audio of you keeps cutting off. I suspect that somebody else has not got their phone muted, and so I'm getting background noise on that. So this alert to the others. Just check to make sure your phone is muted, because Betsy keeps getting cut off.

Betsy Humphreys – National Library of Medicine – Deputy Director

I'll try to be closer to the phone, as well. So the issue really is who are all the stakeholders that we would have to poll or talk to to determine readiness. We obviously heard from a representative of FEB last week. We heard from several large health system representatives, including Jim Walker and Jamie and Chris Chute and Stan Huff, last week. I don't think Clem McDonald is able to be on the call, but an issue that has come up in some discussions he's had is that what happens in terms of the e-prescribing transactions and what is transmitted currently to pharmacy benefit managers. What kinds of systems they have in place and what services they're providing to their clients and what would substitution of RxNorm in e-prescribing transactions or a requirement to use it in e-prescribing, in what time frame, what would it do to that group of people.

Is there anyone on the call today that has any insight into that?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I got some recent mail between Jamie Chang and Clem about this, and basically what—this is a quote from what the Surescripts people have been saying is that the pharmacy benefit managers are all—essentially, their systems are based on proxy NDC codes, much like CMS was for their pharmacy benefits evaluation for Medicare Part D. There are thousands of those pharmacy benefit managers out there, programs, and the question is really whether or not they can alter their way of doing things to switch from proxy NDCs to RxNorm names and codes.

Betsy Humphreys – National Library of Medicine – Deputy Director

Those of us who might have a question about what you mean by a “proxy NDC” —maybe everyone else on the phone knows except me—...what that is?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

A proxy NDC is, as I understand it, a single NDC, which represents a product that they don't really care whether or not it—for example, there may be a hundred NDC codes that represent Propranolol 10-milligram oral tablets. One of those would be used as a proxy. So instead of having to list all of them, they just list one, that this is covered, but somehow they convert from any of these other ones to that one for communication back and forth with Surescripts.

Now, it turns out that CMS was using much the same thing for their medication formulary benefit. They converted to using RxNorm names and codes for evaluation of formularies in a relatively short period of time.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay, so potentially somebody there would be—

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Somebody there could comment on how hard it would be for the pharmacy benefit people to do, since now they're being judged by RxNorm names and codes when it comes around to whether or not they're eligible for Medicare Part D.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. Does anyone else on this call want to comment on that issue? Okay. I think that we'll have to decide or we'll have to figure out what group we need to hear from in order to get a reasonable picture of

readiness. And maybe, in effect, we could try to generate input around this issue potentially in conjunction with messages or solicitation of input that could go out in conjunction with the first release of this prescribable subset of RxNorm. NOM, at any rate, could think about talking to Doug about something like that or whether we could fold that into an announcement of the fact that now there is such a subset and use that as a prod for getting more input on this issue about how hard or easy or quick, or whatever it is, to switch to that.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Yeah. I think the two big groups are—well, first of all, Surescripts, and then secondly, the PBMs themselves. NCPDP may be able to contribute the names of some of the good groups who do pharmacy benefit management.

Betsy Humphreys – National Library of Medicine – Deputy Director

Do we have an NCPDP representative on the phone now? I guess it was Kay—right?—who hasn't been able to join yet.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yeah. I just sent her the dial-in so she'll be on shortly.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Betsy, did we discuss asking people like Stanford, who have put RxNorm into their EHRs?

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah, we did discuss that. In fact, thank you for reminding me. I was e-mailing people and trying to get information during the call last week. Essentially it turns out that Stanford has done something that's quite similar to what a number of other people have done, but it isn't really using RxNorm and e-prescribing. It is using RxNorm when building the clinical data warehouse.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. Thanks.

Betsy Humphreys – National Library of Medicine – Deputy Director

... very different issue.

Kay Morgan – Gold Standard – SVP, Drug Products & Industry Standards Research & Compliance

This is Kay Morgan. I'm sorry. I was here. I was just on the other phone line so I couldn't be heard.

Betsy Humphreys – National Library of Medicine – Deputy Director

Hi, Kay. How are you?

Kay Morgan – Gold Standard – SVP, Drug Products & Industry Standards Research & Compliance

I'm doing fine, so sorry.

Betsy Humphreys – National Library of Medicine – Deputy Director

Not a problem. We're looking at the issue of what are the different stakeholders we would have to get input from to gauge how feasible it would be to move to RxNorm as the standard for e-prescribing in 2013 or 2015. Lynn, of course, told us that there are a lot of people who are assuming this is coming at one point or another and are moving in that direction. That's what Tom Bizzaro said, too, from the drug information provider perspective last week. Stuart just told us that CMS, in terms of what they do in terms of pharmacy benefits has moved from a system that is more similar to what other pharmacy benefit managers use to actually use RxNorm. So they will be a source of how hard or easy that was for them.

Kay Morgan – Gold Standard – SVP, Drug Products & Industry Standards Research & Compliance

It depends on where the pharmacy benefit manager is in the process. If they're in the middle, before it goes to the pharmacy, that's one view, but if they're after the pharmacy, that's a different view. I do know from NCPDP's perspective, the preference is to not have a proxy NDC or an NDC number on the

prescription but rather something more like the RxNorm so that pharmacy isn't receiving some sort of NDC number and feels compelled to use that specific product. So it's a matter of is the e-prescription going to go through the payer before it goes to the pharmacy or after. If it goes before, it will just be a review of is it a paid or not paid concept level.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah. Okay.

Kay Morgan – Gold Standard – SVP, Drug Products & Industry Standards Research & Compliance

... just make it more confusing.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Betsy, I apologize for my ignorance. From the discussion yesterday and today, it sounds as if RxNorm doesn't have a concept such as 100 milligrams of Metoprolol that would be, let's say, nothing more than that so that the pharmacy could fill with whatever was appropriate, but it would still match at a vocabulary level. Is that—?

M

That's not the case.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. It does.

M

It has it.

W

... missing was tablet or whatever? Is that what the question is is you want to leave choice of the dosage more open for the pharmacy?

Betsy Humphreys – National Library of Medicine – Deputy Director

Is that what you were saying, Jim?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

No. Well, I guess the question is always can you say things at a level of generality that allows appropriate flexibility, so that would be one. I mean, you might say, I want to be able to say a 100-milligram capsule, but I don't care which one of the 20 of those it is, but they can't swallow a pill or vice versa.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. So looking at ... hoping to cover today, I think the next issue on our list was medication allergies. Last week we went through the specific parts of RxNorm based on work that was done to the SCRIPT standard and so forth that would be the correct items within the RxNorm draft used for e-prescribing. There was a discussion that that was not the set of things that would be appropriate if we were dealing with a proposed recommendation related to vocabulary for recording medication allergies, so the question then would be would we be dealing with the—what would be appropriate for the recording of allergies. I think we were saying the ingredient level would also be appropriate, and were there any of the things that were specified for e-prescribing that actually would not be appropriate for the allergy level.

Does anyone want to weigh in on this issue? I think the ingredient is definite, right?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes, the ingredient is definite. There are times that you need to put, if the patient knows it, the precise formulation. There may be a dye or something that was in the precise formulation that ends up being the issue.

Betsy Humphreys – National Library of Medicine – Deputy Director

So we were talking last week that we would definitely be dealing with the semantic clinical drug for prescribing and the semantic branded drug. It sounds like if there's a precise formulation including maybe dyes or whatever, that both of those would also be appropriate potentially as—could be recorded as medication allergies.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think so, yeah. Sometimes all you know is that the patient was allergic to a drug, and you don't even know what—sometimes you know a formulation. You don't know if it's the drug itself or a dye that was in that formulation. You just need all that level of specificity.

Betsy Humphreys – National Library of Medicine – Deputy Director

Stuart, is there anything else?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Well, I think Jim is quite right, that you don't need to know—sometimes you need to know, but I think that what the fundamental comes down to is you have to record this information at the highest level of specificity that you know.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I mean, the patient who always drives you nuts is the one who comes in and says, “I'm allergic to 'mycins,’” because what the heck is a “mycin”? But another larger question is: How do you aggregate those groups of things into higher levels? For example, we worry about people who have sensitivity to penicillin, because then they have some cross-reactivity with cephalosporin, so those become larger groups. Now, the fact is that there is no good, consistent naming for these larger groups, and if there's a name for a group, the members—depending upon what particular system you use, the members of that group may or may not be identical. That's a little bit more of a problem, but that's probably—that's something that I don't think is necessary to represent the information at its highest level of specificity, which is the ingredient or perhaps even the actual, particular product that was taken.

W

I think you should also consider latex, which is a big one right now, which is not really an ingredient of any drug product.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Yeah, that's quite true. There are things that don't fall into RxNorm that are things that people can be allergic to.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah. So that's issue—I know that—Jamie, you may remember this if you're not at a difficult point in driving—I think there was a notion that they would pick off the medication allergies first. I don't know if there was also discussion of where we would get all the other important

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

Yeah, and I don't know. Actually, this is an area where we probably should ask ONC how far they want to go in terms of non-drug allergies. I mean, I think certainly a lot of those are covered in the UNII, but I don't know what the policy objective is for non-drug allergies right now. I don't know.

Chris Brancato, could you speak to that at all? I don't think we have Doug on this call.

Chris Brancato – Deloitte – Manager, Health Information Technology

I can't really speak to it, but I will definitely get you an answer. If you looked at the meaningful use objectives for stage one, I think the answer was pretty clear for stage one and that it was medication allergies being the primary focus.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Just as a comment, I know in some cases you will find some things in RxNorm and other places not, but if we were dealing with egg allergy because of avoiding influenza vaccine or other related vaccines, or in some cases, latex shows up, as well, we have seen it in quality measures. I think clinically it has relevance. It's a question of what you want to put on the table to get done.

Betsy Humphreys – National Library of Medicine – Deputy Director

I suppose the issue of identifying any that are relevant to quality measures that are going to be in the picture at ... point, I mean, maybe that—

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

I wonder is there anything that's in the quality measure value sets that are being contemplated for stage two that would not be covered by RxNorm and UNII.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well, I can tell you for stage one, if you use UNII, they're covered, but not by RxNorm, some of them. For stage two, I don't know that we could say, until we actually see the full description, the measures. They're really too vague at this point to know that answer.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah. I mean, I think that there has been no expectation that RxNorm would contain non-medication things.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Excuse me for my ignorance, but is egg allergy included in RxNorm?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I believe that we indicate—but I would have to check on that. I think the vaccines, when it's a virus that's been growing in eggs, I think we indicate that, but I couldn't swear to it.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yeah, I think you do, and I think peanut comes up also for similar reasons, because both of those come up related to some of the meds. But if it's there, it's covered for stage one. I don't know that I could answer for stage two until we see what's actually in those measures and they're not that specific yet.

Chris Brancato – Deloitte – Manager, Health Information Technology

Floyd, I would agree with that statement.

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

Okay. So I'm wondering—our previous recommendations included UNII. Is that still our direction, generally, for non-drug allergies, or is there something else we want to consider?

Betsy Humphreys – National Library of Medicine – Deputy Director

I don't hear a lot of input on that point. Maybe we need to—

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

Well, yeah. What I was going to suggest is maybe just as a straw model for discussion purposes, we could have a directional statement saying that we would use RxNorm, certainly the prescribing subset and anything else that's ... for things that are in the other value sets that are non-drugs and see if that gets us the coverage that we need.

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations

Jamie, this is Tom Bizzaro.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, Tom, go ahead.

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations

Yeah. I think I mentioned last week and I want to mention again that a group from NCPDP has gotten a number of different subject matter experts together to discuss the issue of allergies and how they should be handled in an interoperable healthcare IT system. At the workgroup meeting that's going to take place next week, that white paper, a draft—that white paper will be submitted to the workgroup that has responsibility for this task group, and there will be recommendations, I believe, coming out of that.

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, that will be good. Is this the thing that George Robbins is working on?

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations

It is, yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. Yeah.

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations

Even if that's not approved by NCPDP, it may give some insight into some of the issues that were of concern to that broad group.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, that certainly seems reasonable. So we'll have to get a hold of that report. I'm assuming that it's going to be reported out at the meeting and that will be a version that is not somewhere right now where we can look at it. Well, we might as well wait and see what NCPDP does with it, anyway.

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations

Yeah, I would recommend that. I know that it isn't a very complete draft. It will, I'm sure, change as it gets in front of the entire workgroup, and then a decision will be made as to whether or not to publish that as a document from NCPDP. The intent is as a letter to ONC with those recommendations, or to not necessarily ONC but to either this task force or the ONC Standards Committee.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. Great.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Betsy, are dyes part of RxNorm or UNII? I've had patients that knew they were allergic to Yellow Dye No. 2, and that needed to be part of their record. Is that possible?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I could tell you that it's not in RxNorm, because it's considered to be an inactive ingredient. I believe it does—it should have at UNII.

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations

It does have at UNII.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. I actually think that in terms of what we were planning on discussing today related to medications, e-prescribing, and medication allergies, we have at least run through the topics. Are there any other comments from members of the task force on the phone or from anyone who's on the phone, that's been patched in, on these issues?

Tom Bizzaro – First DataBank – VP Health Policy & Industry Relations

Betsy, the comment was made, and I'd just like to reinforce it, the use of a proxy NDC and e-prescribing or in the desire to know whether or not a drug is covered within a formulary I think was put in place

because we really didn't have another way of having a common drug concept identifier. As you look at RxNorm and the level of concept that it does define, its use within e-prescribing or, as we've seen proven somewhat with CMS use of RxNorm codes to define a drug within a Medicare Part D formula, I think examining that further would be recommended. I was glad to hear the task force talking about seeking out that type of information, because I do believe RxNorm is going to fit well into that type of a scenario.

Betsy Humphreys – National Library of Medicine – Deputy Director

Thank you, Tom. It does seem, for many reasons that we could all come up with, that use of this proxy NDC is not very desirable, even though it may be workable for some things right now.

I think that Jamie and I were discussing where we should go, having gone through the medication issues at the level we have, and then we will follow up to get more input in terms of experience with the implementation of RxNorm or other indicators of what would be the issues associated with readiness for moving to it. But the next set of items that we would take up is the issue of specifying terminology and moving toward tighter requirements in 2013 or 2015 for labs. I think we're at a point, here, where we don't have Clem or Stan or Dan Vreeman on the phone at the moment, and it seems to me we would get a better discussion of that or a better knowledge of what the state of the situation is, there, if we had one or all of them with us. And then we would be scheduling also to discuss issues around the problem list.

So if those who are on the phone now do not have additional items that they would like to bring up about terminology for e-prescribing or for allergies, then I think we might be ready to open it up for public comment. But first, does anyone on the working group or on the phone already wish to say anything more about vocabulary for e-prescribing—any other medication vocabulary issues or allergies?

All right. Then I think we're probably ready to open this up for public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Right. I guess, Betsy, what you were saying, too, is on the next call I should make sure that Clem and Stan and Dan or at least one or two of them are on the next call, when we talk about LOINC.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that that would be valuable. I suppose Jamie and I could discuss whether we could reverse the order and talk about problems—

Judy Sparrow – Office of the National Coordinator – Executive Director

Yeah.

Betsy Humphreys – National Library of Medicine – Deputy Director

—... labs, if, for whatever reason, they weren't available at the next—

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay. We can talk about that.

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

And it might be actually a different list of key participants for the problem list, as well, but let's try to go for our next one or two calls to talk about lab results.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay. Got it. All right. Thank you. Thank you, everybody. Operator, can you see if we have any public comments?

Operator

We do have a comment from Carol Bickford.

Judy Sparrow – Office of the National Coordinator – Executive Director

Great. Thank you. Carol, go ahead.

Carol Bickford – ANA – Senior Policy Fellow

I'm Carol Bickford, from the American Nurses Association. As a healthcare consumer and also a clinician, I'm very concerned that the components of the medication, for example, the dyes and other inert products, are not necessarily incorporated in any of our terminologies. Because as a consumer who has some difficulties it creates a nightmare for dealing with a prescription and what constitutes the inert ingredients. So if there's a mechanism to address that deficiency, that would be awesome from the standpoint of a consumer's perspective.

Betsy Humphreys – National Library of Medicine – Deputy Director

Thank you, Carol. I believe that it certainly is the intention of the FDA and the UNII development that there be UNII-unique identifiers and names for the inert ingredients, as well. Use of the UNII, certainly in terms of allergies, was something that had been previously recommended by the Health IT Standards Committee, and as Jamie had pointed out, we would probably be reiterating that recommendation.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Do we have any other public comment?

Operator

There's no more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay. Well, thank you, Betsy. Thank you, Jamie.

Betsy Humphreys – National Library of Medicine – Deputy Director

I thank everyone who was able to participate.

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

Thank you.