

**Clinical Quality Workgroup
With the Vocabulary Taskforce
Draft Transcript
June 20, 2011**

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to a joint meeting of the Clinical Quality and Vocabulary Taskforce. Let me do a quick roll call, and also a reminder, since there are so many of us on the line please identify yourselves when speaking. Jim Walker?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Karen Kmetik? 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

David Baker? Anne Castro?

Anne Castro – Blue Cross Blue Shield South Carolina – Chief Design Architect

I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Chris Chute?

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

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Bob Dolin? Floyd Eisenberg?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Lansky? Gene Nelson?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Eva Powell?

Eva Powell – National Partnership for Women & Families – Director IT

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Philip Renner?

Phil Renner – Kaiser Permanente – Principal Consultant, Metrics Development

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Danny Rosenthal?

Daniel Rosenthal – National Quality Forum – Senior Advisor, HIT

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Joachim Roski? Rosemary Kennedy?

Rosemary Kennedy

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Rallins?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Pamela Cipriano?

Pamela Cipriano - ONC

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Aneel Advani?

Aneel Advani – Indian Health Service – Associate Director Informatics

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Patrice Holt? Ken Gebhart? Heather Stevens?

Heather Stevens - Accenture

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Rallins?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Hi. You called Marjorie Rallins, but Marjorie Greenberg is also here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay, got you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Stan Huff? Marc Overhage? Daniel Vreeman? Don Bechtel? Patty Greim? Chris Brancato?

Chris Brancato – Deloitte – Manager, Health Information Technology

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Andy Wiesenthal?

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Amy Gruber?

Amy Gruber – CMS – Program Analyst

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Ram Sriram? Lynn Gilbertson?

Lynn Gilbertson – NCPDP – Vice President of Standards Development

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Nancy Orvis? Anthony Oliver? Did I leave anyone off?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Stuart Nelson.

Judy Sparrow – Office of the National Coordinator – Executive Director

And Stuart Nelson, thank you. With that I'll turn it over to, I guess, Jim Walker first.

Jon White – AHRQ/HHS – Director IT

And Jon White's here too.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Stan Huff is here too.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, Judy. First, let me thank both of the committees for attending in such great numbers. We intend and hope that this meeting will bring together and establish a clear consensus, at least on many of the code sets that will be needed going forward. And obviously this is the culmination of decades of work by lots of people who have developed these terminologies with limited resources and more limited support, and then more recently the Vocabulary subcommittee and the work of Tom Tsang and particularly Floyd Eisenberg and the rest of NQF, and then the Accenture team that has helped us in the last couple of weeks bring this to final shape.

The shape of our discussion today is to try to identify a clear consensus on the appropriate code set or perhaps a very small number of code sets for each of the 23 data categories in the quality data model. In the likely event that we can't achieve clear consensus on all of them, I think what we want to do as clearly as possible is identify the issues that need to be resolved and the information identified, whatever else would need to be done to enable us to get to clear consensus on all of the code sets that we'll need.

With that, I'll turn it over, I don't know if Karen's here yet, but maybe, Jamie, you could take it over.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

I just want you to know I'm on. It's Karen.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great.

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

Thank you very much. I think, Jim, you're really going to lead us through this discussion, and that was a great brief introduction. Do we want to just dive right into the spreadsheet?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Sure. I think Tom and, who else was it, Tom and someone were going to give us some background on the code selection test, Tom Tsang and Pam Cipriano, if they just want to give us a little bit of background and then we'll go right into the spreadsheet.

Pamela Cipriano - ONC

Sure, Jim, this is Pam, because Tom's not able to be on the call today. As the workgroups have been addressing some of the concerns that have been identified for making sure that we can move forward with the quality data model, working through straw man examples of that, it also became apparent that from a standards perspective that it would be beneficial to have one code set for each of the 23 concepts embodied in the quality data model version three. And so, as you mentioned previously, Floyd Eisenberg has been very helpful in helping the quality measure groups to really look at what the alternatives are that are either included in current meaningful use or included in current convention and the options. And what work has transpired up to now is we have worked with Accenture, and Heather Stevens is on the line from Accenture, is to talk with expert groups, both with individual members of the Vocabulary Taskforce and the Clinical Quality Workgroup, as well as reference groups and measure developers who can inform this discussion. And through that process they have made some draft recommendations that we want the group to work through one by one to see if we can come to agreement, as you mentioned, to have consensus on the selected code set that would be recommended for each one of these concepts. You might also want to let the group know that you may take a few of them out of order, the ones that have a little bit higher complexity and that may not have immediate consensus, so that we may put those for discussion at the end of the call.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great.

Pamela Cipriano - ONC

Jim, let me just add one other thing which you may be saying along the way, but one of the other points of discussion preliminarily was to look at whether or not there is perhaps one primary source that covers the majority of these areas, with the belief that in the future we will move away from using ICD-9 and ICD-10 for clinical measures and reserve those for measures associated with financial and billing codes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, Pam. Let me maybe just quickly for discussion propose what we have been talking about at least and check its accuracy against the joint teams' understanding, because it does condition the discussion of many of the characteristics of the QDM. My assumption is, and my read of ONC's road map is that the plan is that SNOMED becomes the core code set for clinical documentation, expression of clinical realities, and that, of course ICD-9 goes away shortly, but that ICD-10 is also seen as ephemeral

as a clinical code set, although it will obviously continue to need to have mapping from SNOMED to ICD-10 for billing and other administrative purposes. Is that a reasonable understanding of the planned road map?

Pamela Cipriano - ONC

Yes, Jim, that is.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. And is there anyone that has – I'm sorry, who was that that replied?

Pamela Cipriano - ONC

I'm sorry, Jim, that was Pam responding from an ONC perspective.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Is there anybody who wants to nuance or correct that, or are we comfortable with that as a –

M

Yes.

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

I don't know that I'm in a position to correct it, but I would point out that IHTSDO and WHO have reached an agreement where ICD will eventually become the aggregation layer within SNOMED and the recognition that ICD still plays a legitimate role in the context of aggregating or having higher level categories of clinical concepts, I don't think is abandoned by either group. I think it would be a mistake to look on ICD exclusively as a mere billing artifact.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, Chris. Let me just check my understanding. In your mind, does that mean that it would make sense to say SNOMED and 10, or SNOMED to include 10 down the road?

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

Actually, SNOMED will include 11. For purposes of 10, I think we should talk about SNOMED and 10

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I'm sorry, I lost just the last part of that sentence, Chris.

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

SNOMED will include 11, not 10. For purposes of what we're discussing I think it's appropriate to still talk about SNOMED and 10 for clinical aggregations. I think the expectation is that SNOMED would be useful and preferred for detailed clinical observations, whereas, 10 still plays a legitimate role for higher level aggregations in the context of public health, arguably quality, certainly epidemiology and outcomes and related activities.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, so is the rest of the group then comfortable with Chris' schema that it probably makes sense, although we obviously will leave it to discussion of the individual categories, but that it probably makes sense to think in terms of SNOMED and 10?

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

Jim, first of all, I agree with all the uses for 10 that Chris outlined. But that's different from what you said, because what you talked about was about the original clinical documentation, which is of course not at the aggregate level. I think the uses that are not purely billing that we have for 10 are very important. They're in the reporting analytical/analytical sphere of public health reporting and analysis and things of that nature, for the most part. But I think that's different from clinical documentation and I think what we're talking about in the original EHR documentation for purposes of meaningful use really is the clinical

documentation purpose. So now when we move into other requirements in terms of aggregate reporting I'm completely in agreement with Chris that 10 still is an important component of that.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Jim, one question that I think would help me evaluate this a little bit more easily is, number one, what is the timeline on this? And B, regarding this change, what would physician practices and their staff actually experience? Is this essentially hidden from them as behind the scenes coding of the EMR, or is this a terminology they would need to acquire if they don't have it? Or is there some other work required for them that is different from what is done today?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Let me address number two, and maybe Pam or someone can address the timeline specifically. As I understand it, for Meaningful Use Stage 3 SNOMED is the standard vocabulary, that 10 will be acceptable for MU 2. As far as how clinicians experience this, in a perfect world their vendors would build it into their HIT products and it would be fairly invisible to users, I believe, except that they might have more usable codes available to them when documenting their patients' situations. Jamie or Chris, is that close enough?

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

I don't disagree with that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Pam, can you tell us more specifically the timeline, or is there someone else on the call that can do that?

Pamela Cipriano - ONC

I'm wondering, is Anand on the call?

Anand

I'm here. I'm sorry. I was on mute.

Pamela Cipriano - ONC

That's okay. Anand, do you have a sense in terms of the ideal timeline for having this code set identification?

Anand

I think we're looking at aligning it with the Meaningful Use Stage 2 recommendations.

Pamela Cipriano - ONC

That was my understanding, but I was not positive.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. Currently, I think the Stage 2 recommendations were that ICD-10 and SNOMED would both be acceptable codes.

Anand

Yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay.

M

And this is really just talking about the diagnosis side or the procedure side too?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think that's probably a more detailed conversation. Maybe we can use that as a prompt to take Jamie's good advice and go into the spreadsheet.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Jim, on a different aspect of this, I agree completely with what's been said. I just want to nuance the fact that in the representation there are really two kinds of codes that we're talking about. We're talking about what we've been talking about so far, what I would think of as the values of allergies or characteristics or whatever, and then there are the observation identifier codes which are LOINC, and it's a combination of those two codes that lead to the common representation.

So it's a recognition, I guess in what we're talking about here that you need to get more specific about exactly where we're using the codes. And it comes back to modeling, and I don't want to get into all of that part, but there's a code. For instance, if you just talk about allergies, there need to be codes that say this is the allergen, this is the degree of, there's something that identifies that field or slot and then there's the value of the slot. And the LOINC codes are used for the names of the slots, if you will, the name of the field and the structure that you're filling in, and then either SNOMED or, as we talked, ICD-10 codes end up being the value to those things. But there needs to be more of a recognition of that even in the table, what the role of the LOINC codes are, that I had established a slot, or established that this is the name of a problem, or this is the name of a final discharge diagnosis, rather than just assuming that context in the discussions.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, Stan. We made some movements toward that in the spreadsheet you have before you, but I think you're right that as we go through each one we want to make sure that if LOINC is needed to serve that purpose that you're talking about, that we make sure that we add that.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Stan, I very much appreciate that comment. As we look through the spreadsheet we might want to think about just what you said, think about the result of it being, or the actual values versus the observation as we look at each of these. That may be very valuable.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Patricia Greim – VA – Health System Specialist, Terminology

I just want to say that I've been on after the roll call and I just want to lend support to the comment that we've been focusing on terminology values and that the field names are very important to VA and we'd like to see LOINC and SNOMED represented.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Any other comments on this, or are we ready to – and obviously we'll have a chance to test these higher level, it sounds like pretty clear agreements we've come to in the individual cases. So if everyone's ready why don't we go ahead and look at the spreadsheet then. Who's going to take us through that?

W

Jim, we thought you could walk through. Heather is on the phone. If you want her to do any additional introduction, she certainly can do that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, I'll be glad to do that walk through then. The first concept is adverse effect, either allergic or non-allergic, and the team felt that it was appropriate to join these two concepts together since the code sets that are required for them and the logic applied to them is pretty similar. Here you see the recommendation that, and I apologize, at least for me the slide is hard to read, so you probably want to try to look at the spreadsheet as it is on your computer. But at any rate, the recommendation here is that SNOMED CT be for substances, RxNorm for medications, and then a question about UNII. Now, I don't know, Betsy, if you want to talk to that letter, I think that's probably germane to this discussion as maybe a starting point.

Clem McDonald – Regenstrief – Director & Research Scientist

I was on the wrong kind of line. I was listening but I couldn't talk. I just wanted to let you know that I'm here.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great, thank you.

Betsy Humphreys – National Library of Medicine – Deputy Director

I first have a question. Maybe this is for Floyd. We're dealing with this context of quality measures, are we not, this whole list?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes, we are.

Betsy Humphreys – National Library of Medicine – Deputy Director

So the question that I would have is, are we in fact dealing with quality measures that relate to all types of allergies, including, for example, food allergies?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Betsy, the answer is yes. And one of the questions here was what do we use to indicate the type of allergy, which would be the observation there is an allergy and what kind. Then paired with to what am I allergic; substance that is non-med and substance that is med. It actually mixes a few concepts and I apologize for that ... but we need all of those.

Betsy Humphreys – National Library of Medicine – Deputy Director

I just

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I'm sorry, Betsy. I think you're cutting in and out.

Betsy Humphreys – National Library of Medicine – Deputy Director

Sorry. Shortly after

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I can't hear you.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

You're still cutting in and out, Betsy.

Betsy Humphreys – National Library of Medicine – Deputy Director

You can't hear me?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I heard that.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay, I've picked up the phone. Shortly after the last meeting that the Vocabulary Taskforce dealt with medication related issues we received recommendations that came out of a working group led by NCPDP and some other groups that focused on the issue of allergies and allergy classes. They came at it, I believe, Lynn, I know is on the phone so she can perhaps give more background, but they came at it from the point of view of medication allergies, but also other allergies. Their recommendations were around the use of RxNorm rather than any local codes and commented that RxNorm for the medication related activities allowed you to specify the allergy at the correct level, that is, if it was to the ingredient or so forth, and particularly with the integration of the NDF-RT classes. I believe that they were suggesting that over time we should somehow move into the same structure, the common non-medication allergies, ...

allergens, that's not something that we have had a chance to discuss, and they had other recommendations related to the coordination of this activity across government agencies.

So we need to discuss those recommendations. I myself look at the recommendations laid out here and I do think that irrespective of how we distribute it, and a joint distribution or a package that included common, non-medication sources of allergies together with those that are more medication related might be very valuable. But what is recommended here makes sense to me in terms of SNOMED CT for substances that are not medications.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Any other comments about the recommendations here of SNOMED CT, RxNorm, and then I'm not sure how to read that, is the recommendation that UNII be part of the third code set here, I think?

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

The problem with RxNorm is that it pre-coordinates all this dose and tablet size and so on and so forth in a way that makes it slightly bizarre as an allergen, and you could be allergic to a 500 mg tablet of penicillin but not to a 250 mg tablet of penicillin, and that makes no sense. UNII has the –

Betsy Humphreys – National Library of Medicine – Deputy Director

Chris, I think the fact is that RxNorm has all the different levels of granularity and in terms of the aggregation along dose forms, that, as you may know, is available in RxTerms, and we're working on a joint distribution which might take care of that problem.

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

Okay, so if you're calling RxTerms part of RxNorm, then that's fine. It's just that I think people have a surface level understanding of RxNorm that is more at the user interface level. Where I was going with this is to say that UNII is at least more holistic when it comes to characterizing substances as drugs that would be arguably allergens, and includes, as you know, compounding agents that are not necessarily drugs and included in RxNorm per se, but to which people can have meaningful allergies.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that the UNII level is represented in RxNorm, but Stuart's on the phone and can verify that. RxNorm at the moment does not include, or now does not include the non-active ingredients certainly.

Clem McDonald – Regenstrief – Director & Research Scientist

Chris, to clarify, I think the ingredient level is what will be used for in RxNorm but will be used for the allergy, and the RxTerms is going to be incorporated in a full-fledged way.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

That was Clem. This is Jim. My understanding was that we would need UNII for things like allergy to yellow dye #2. Is that also available elsewhere than UNII?

Betsy Humphreys – National Library of Medicine – Deputy Director

Not presently, to my knowledge. But somebody else on the phone may know more.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

SNOMED substance hierarchy has things like that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. Can someone, Floyd or one of the Accenture people, what is the thought about the need for UNII then?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Actually, the reason that UNII's listed here is I wasn't aware of the letter that came to the Vocabulary Taskforce after the call when I heard on that call that UNII was being considered. As long as the

substance, that is the component that's supposedly inert, can be expressed in SNOMED, I don't think that's problematic. I just wanted to make sure we could say it.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, so then I think the proposal in front of the group is SNOMED CT for substances, RxNorm for medications, on the understanding that it has the right level of granularity for allergies and when we confirmed that the substances that UNII would cover would be available in SNOMED CT we would just remove UNII from the recommendation. We need to have full discussion and ensure we're really all comfortable but also move as fast as we can, is that okay with people? Is there any other thing to consider?

M

Just to clarify, I think substances is a more generic term, and I think you have to qualify that by substances that are not in medications.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. And I misread, the spreadsheet says "substances non-medications," that would be okay?

M

Yes.

M

... CVX and MVX for immunization, CPT related immunizations?

M

That was the other question that's over on the far column, because for Meaningful Use Stage 1 reporting to public ... agencies requires CVX, and since that's a procedure technically how would one apply the allergy or does one also provide the RxNorm?

Clem McDonald – Regenstrief – Director & Research Scientist

From the point of view of the data gatherer, they're going to often have it entered as a CVX, MVX, and I don't know whether that would cause havoc, but it seems to me it would be easiest to say with that that they could just use that as code. That's being required all over the place.

M

Yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Then the proposal would be that you could use either SNOMED or CVX, MVX.

M

I think it should be CVX, MVX.

M

I agree.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

There was a question if someone took a history and documented vaccinations for patients but did not administer the vaccinations that CVX would not cover that case. Is that not true?

M

If you just look in the tables it's just saying what the vaccine is. I know it's being used to record the administration, but it's a code that says the name of the vaccine.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Actually, I've looked at CVX and it doesn't really specify the vaccine. It's a class of vaccines. So it will say something like influenza A, but we know that the influenza A vaccine changes every year, and so it's really a class of vaccines. RxNorm has vaccines but we have it down to the very specific level of what the components of that vaccine are.

M

CVX does that too, it's not just the class that gets into more detail, individual preparations.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This has the sound to me of something that we might want to refer to the Vocab Committee to come up with a recommendation that may be beyond the scope of today's meeting. Are we comfortable with that? If so, then I think the proposal would be that it's SNOMED CT, RxNorm, and that we'll ask the Vocab Committee to confirm, well, I guess SNOMED CT, RxNorm, and CVX, MVX, and have the Vocab Committee comment on whether CVX, MVX is needed or could be covered by RxNorm, although I guess Clem's point is that there are so many people who are using it because of the requirement that they use it that it would be –sorry, so then it seems to me the proposal before us is SNOMED CT, RxNorm and CVX, MVX after we confirm that CVX, MVX is fine grained enough that it can be used in that way as well as RxNorm could. Is that all right with everyone?

Aneel Advani – Indian Health Service – Associate Director Informatics

I'm just wondering if we can come up with a principled way when there's multiple possibilities to choose the one for the standard. And one suggestion is to pick, for the standard reference that everything else can map to, the vocabulary that has the most detail and the finest distinctions, as opposed to the one that is the most commonly accepted aggregate, because I think that will have the most longevity.

M

I don't think that's going to always work, because it's going to put a huge burden on the submitter. If someone says, "I got an allergy when I had my vaccine last year," how are you going to get that detail?

Aneel Advani – Indian Health Service – Associate Director Informatics

Right, but from the point of view of the quality measures, they express them with the least amount of divergence in interpretation, it may be better from the perspective of quality measures to say, okay, well, we expect you to be able to map whatever you have on to this more fine-grained kind of reference, so in that case it would be up to the people supplying the answers to that measurement to map from what they were using.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Is this one that we can imagine a road map in which CVX, MVX is accessible for some period of time and then needs to be mapped? That mapping, I assume, is going to take time.

M

I think you're not going to be able to get this settled today, and I don't think we can decide principles like that today, so you need some other option. I think also when you say, you know UNII is for one category, RxNorm is for another category, and then the question really applies to the immunization category under the context of allergies, and there are different opinions. I don't know how to sort them out except by having a brief committee meeting and what –

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think it may be the same issue when we talk about medications. But I don't disagree that it might ... a separate group.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Jamie and Betsy, is this an appropriate question for the Vocabulary Committee then?

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, I think it is.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay.

Betsy Humphreys – National Library of Medicine – Deputy Director

And I heard two questions. One was whether in fact we need UNIs or not. And also the CVX, MVX, I have to say that I was just looking at the CVX codes and either I haven't found the right one, which is entirely possible, or I just don't see very much information about particular flu strains, but at any rate.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So that would be an important issue to identify that. That would have the virtue of making our decision easier if that was not there.

Clem McDonald – Regenstrief – Director & Research Scientist

To stay on that point, again, as a clinical person no one I ever talked to knew what exact strains they got when they got the flu shot. They knew what year they got it, and that usually identifies which one ..., so the question is can you get it out of the systems to report it?

Betsy Humphreys – National Library of Medicine – Deputy Director

I think you're right there, Clem, and I think the other issue is how is it handled. If in fact somewhere there is a source of information that's available to everyone that actually tells them year by year what it was, then maybe that solves it. But then the issue is, is that available to everyone? I guess we should make it available if it isn't.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I think we try to put in the year of that vaccine in our names or synonyms.

Clem McDonald – Regenstrief – Director & Research Scientist

In the immunization messages where it's become very established and it's being used, I always worry if we get standards going the first thing you want to do is not change them to a different one, there are other fields, which include when given, etc., and I think even the lot number.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Very often, like the ineffective hepatitis A several years ago, that was a matter of lot number and knowing which lot number a patient had gotten to know how to respond. So I think that is one important potential here, that lot number may solve the granularity problem.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think it gets back to Stan's original position of what's the context where you're using the vocabulary.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

All right, so I am taking this that further discussion of both the UNIs versus SNOMED CT and the CVX, MVX versus possibly RxNorm are to go to the Vocabulary Taskforce.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Jim, one more question, did we move out of scope the descriptions of the manifestation that happened to the patient, you know, things that would say what kind of adverse event happened to the patient? It

doesn't seem to be here now. It was in the first draft and then I didn't know if it just got lost or whether it was intentionally taken out of scope.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Stan, from my perspective I think it got lost. But we did want to be able to indicate the type of allergy.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes, we did.

Betsy Humphreys – National Library of Medicine – Deputy Director

The type of allergic reaction?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think the seriousness of the adverse effect was at least one thing, so at least clinically there can be an allergic reaction that's far milder than a non-allergic adverse effect. And at least one of the things that's needed clinically, but probably also from a quality standpoint is, was it lethal, life threatening, serious, or mild, or something like that.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think the original intent was to say what type of allergies or adverse effect, type 1 hypersensitivity or otherwise, and we do have a category, an attribute we call "severity," which we didn't add in here because it would have added to a much longer list where we've just been applying SNOMED, but if we want we can get into all of those details. What we were looking for is the reaction itself that you're looking for.

M

This spreadsheet may not be the place to do it, but I'm sorry to keep harping on this, but you don't get interoperable working at this until you specify that model and it shows, oh, here's a slot for the allergen, here's a slot for the ... station, and here's the severity, here's a slot that says whether it was confirmed or not. We really need to say the information model that we're working against and where we use these terminologies are just, you're leaving things unspecified basically that hopefully you want people to note to make it truly interoperable.

Clem McDonald – Regenstrief – Director & Research Scientist

Some of these things I thought were specified in the HL7 allergy segment. Was that –

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

That's exactly the point is we should say, if we wanted to say that we could say we're assuming that the HL7 allergy segment is the underlying structure for this information, whether you physically use that or not, that would be the defining characteristic of the fields that you're filling in with this information.

M

Right, so for Stan and Clem, that is how the QDM model was derived. I think that would be helpful, we stated that, but it does have severity, it does have the fields you're talking about. We started with the higher level categories but we do need advice on all the sub-categories, the attributes is what we call them, but we

Eva Powell – National Partnership for Women & Families – Director IT

I apologize. I'm not sure exactly where to interject, but from a content standpoint, and it may help with some of the issues being discussed, is distinguishing between an allergy and a side effect, because I

know from the quality measure exclusion world that oftentimes those words are used interchangeably but they're not really the same. And from a patient perspective, understanding the side effects, even though it may not be an actual allergy, will be really important in terms of engaging the patient in decision making and those kinds of factors. I think that that will need to be captured somehow, although I don't know exactly if there's a standard for that or if this is the appropriate place to do it.

M

I think there is already and it will be discussed in this today. ...called –

Eva Powell – National Partnership for Women & Families – Director IT

Yes, I haven't really looked at the spreadsheet in complete.

M

... adverse events or adverse reaction, I think it's called, but I'm not sure.

Lynn Gilbertson – NCPDP – Vice President of Standards Development

I just wanted to make a note that in column D there are two references in row 4 and then further on down that reference the NCPDP Formulary and Benefit Standard with the adverse event and allergy situations. That is not a correct statement. The Formulary and Benefit Standard is not used for exchanging adverse events or allergies. So I just wanted to make sure that was noted.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, Lynn. We'll get that fixed.

Patricia Greim – VA – Health System Specialist, Terminology

I just want to concur with Betsy Humphreys' remark about context and wherever we can make that explicit. If it means identifying HL7 messaging structure as required, that would be great.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think in some version of this, under allergy that would apply to adverse effect we had listed the proposal of SNOMED to indicate what that was, and to make sure it's within the HL7 messaging structure would be a nice addition to that. That's a proposal that you can consider.

M

If there is an allergy content ... guidance, I'm trying to find it right now under HL7 in some table. I'll let you know if I can find it.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, why don't we move on to number two, patient characteristics? Floyd, I'm having trouble reading my spreadsheet. Can you tell us the proposed code sets for that?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes. What was listed here was characteristics actually covers a number of elements, ... age and meeting the birth date as the observable. The other was gender as the observable. Another is race, ethnicity, behaviors, resources, preferences, and some miscellaneous things like tobacco use, where there was no other place we could see to fit that. And so the recommendation was HL7 provides ... code sets for demographic information and to use those for elements such as behaviors, resources, and preferences where it's not in HL7 to use SNOMED CT.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

My understanding was this was one of the places where LOINC might provide what I think of as the questions that define the answers. Is that the case?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. Especially in the case of smoking status, you need, along with the things that say Caucasian and black and those kinds of things you need something that says this is the race field and that could be

theoretically either SNOMED observable or it could be a LOINC code. So I think we need to break this and say what code system are we using for the observables and what code system are we using for the values here.

Heather Stevens - Accenture

Jim, when we talked about questions and answers that was for the physical exam.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right. I think the discussion here is that it probably extends beyond that.

Heather Stevens - Accenture

Okay.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Actually, what Stan described is exactly what we need. We need what is the observable and also what we were actually looking for here was what is the result of the observable, how do you describe it. But having that the observable, whether it's SNOMED or LOINC actually is important because it's confusing when we have either/or ... we have to provide those.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

What is the specific code set proposals here?

Clem McDonald – Regenstrief – Director & Research Scientist

Can I just interject? This is a hodge-podge, I believe, of different things that. Aside from the demographics, which are well defined here, ..., there's a whole huge range of stuff. Insurance coverage, that's got well defined fields and various ..., and then other things are things that are sort of survey instrument-ish preferences, there are lots of survey instruments about those. So this is very wide-ranging and either I'd call them all survey instruments and then try to deal with that aspect, but carve out some of these that belong in financial messages, for example, ... these are huge and blended and not clear.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

To me the proposal to say, look, there's a whole set of survey instruments and they might be patient characteristics and they might be behaviors, they might be parts of the history, they can occur across lots of the different segments, but treat all of those as one set that would have one set of code sets to support them, is that something that makes sense to people or not?

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that I'm more in line with Clem's first comment, which is if in fact this wide range of different things is required by quality measures, then it seems to me that the right answer for each one, I mean, you have to look at them separately to figure out what makes sense in terms of what people are already using and what might be ... problem and what requires more work.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

What I can suggest is they can come back to you with some of that definition. It's not clear in the cell that we actually had assumed something around survey instruments for preferences and behaviors, and for specific elements we were asking for advice, but it's not clear in the cell so we can make that specific.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So as I understand Betsy, for discussion for people's comments, what we need to do is specify each one of the instruments and the code set that would be appropriate to add, and if there are a number that the same code set would be appropriate for, we can certainly put them all together. Comments on that?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

... on preference it looks like ... 17 deals with preference and that may be covered better there. Specific to smoking status, that might be part of risk evaluation and might be better covered there.

M

One of my thoughts was there's too many categories here and we're going to end up fussing over which cell it's in, and it doesn't matter too. We've got an awful lot of cells to worry about and I think most of them are survey instruments.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

My question, I think probably to Floyd, this is Stan, was this meant to be an enumerated list of things that you wanted specifically in quality, or was this meant to be more of a starter set of things which you intended to extend as quality measures, perhaps, that would require additional information in this area?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Thank you for the question, Stan. It really is a starter set, meaning that we know we have to deal with behaviors and so if there's a standard approach that would say that's going to be handled in survey instruments, whether you call them risks or characteristics ... moving around, then we would expect that those creating the instruments would register them in LOINC, for instance, and then that would be the way these move forward. We can't necessarily know everything that's going to be needed as we move toward shared decision making and patient reported outcomes.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

In that case then I would just recommend, and I'm expressing my preference and I understand that others can have a different preference, I would prefer then that we say here that we use LOINC code and LOINC survey representations for all of these items.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Stan, I assume with except the few for which there are widely accepted categorizations currently, gender and that sort of thing. Or would those be included also?

Betsy Humphreys – National Library of Medicine – Deputy Director

Would that ... LOINC answers for the questions?

M

I think those are done. They're done by HL7 as specified here, and I wouldn't worry about those.

M

Yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Stan, is that an acceptable amendment to what you're saying, is that the ones that are done by HL7 be excluded and for everything else we would do as LOINC?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes, that's perfectly acceptable.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Do we have any comments, corrections to that, or nuancing?

Betsy Humphreys – National Library of Medicine – Deputy Director

I just have a comment. I think that there's somewhat of a goal that we may achieve that in some cases the answers to the questions, if they're appropriately represented in SNOMED, that that is the direction that we would go in and that in effect LOINC would also indicate what the answer is in SNOMED.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Correct. That's absolutely right. In fact, we proposed that once in another dialogue of this, but yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Any comments or contra, putting all of the surveys, and the team will create a list to circulate so that we can confirm that we got that right, but that all of the surveys would be in LOINC and SNOMED for question and answer?

Clem McDonald – Regenstrief – Director & Research Scientist

Could you say the questions would be in LOINC and the answers would be in SNOMED?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Sure. Any problems with that?

M

Not all of the answers are currently in SNOMED, I guess, so they will be in SNOMED where SNOMED is available, or LOINC, I guess.

Betsy Humphreys – National Library of Medicine – Deputy Director

In some cases they're actual things like the answer is 1, 2, 3, 4, 5, too.

M

Or it's a sentence. But I think we can accommodate –

Betsy Humphreys – National Library of Medicine – Deputy Director

... where appropriate.

M

Yes.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Our experience is that we submit new content when there are gaps in SNOMED, and they're very amenable as long as things support their concept model. I wouldn't worry so much if the content isn't there. It's more if the terminology is able to accept them.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great. All right, the take home on that one then is that for things that HL7 has done HL7 will be the code set, for other surveys LOINC and SNOMED will be, as enunciated previously, and the team will get a list of surveys out to both workgroups so that people can comment on any specific issues with those lists. As I think is clear from the discussion, some of them are in category two, some of the surveys are elsewhere throughout the spreadsheet, and we'll bring those all into one group.

M

Jim, the only thing I'd question about some of the surveys is the fact that they may be in LOINC as observables. It would be up to the measure developer to determine which of those applies to their measure, and in fact if there's a new validated survey they want to put into LOINC and have registered, I don't know that we want to limit it.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right.

M

Yes.

M

There's a lot of good surveys out there that aren't yet coded.

M

Right.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes. Okay, great. If we're okay then we'll move to three, communication. Is it Heather or Floyd that's giving a –

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I can give some background on this. This was just to indicate that communication has occurred between two individuals, meaning between a patient and a provider, or a provider and a provider. This is the act of communicating, not the content of it. The content of it would be, so it's the same as having the observable that communication occurred and two the content of it would be a separate issue.

M

How would this really happen? There are telephone logs, I mean, you really are dealing with a structure here, I think, that may exist or may not exist. There are notes, there are e-mails –

M

....

M

... the practice is going to have to go out and record, I have to do an e-mail that I sent a message.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Good point. So in Meaningful Use 1 these were not endorsed measures, but they were measures of sharing a summary with the patient, and that is, there's communication with the content of a summary. There hasn't been a way to express that in a standard way for measure developers, so that's why we're looking for communication. How it's implemented will require some work, understandably. Is it from a telephone log? Is it from the audit file from the EHR that indicates something has been transmitted and acknowledgment received? That's something that needs to be discussed, but we needed a way to be able to express it and the way it's done in existing measures is attestation I did the communication.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Floyd, just a little more about the level of detail you're trying to capture, is it really at the level of just saying something was communicated to the patient at this stage in time? Or, is to say maybe one more level specific, a summary was sent to the patient or a consent was obtained or something that indicates not the detail of whether it was a pathology report or an operative report, but the category of information exchange, a living will, a summary of data? What's the level that you're trying to capture with this?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

The level is and some of the measures really is down to the level that we have communicated the need for an advanced directive, and the advanced directive was received, so the content specifically, or that the consent was for a type of surgery. So many measures, in order to do that, would just ask for attestation and perhaps ask for a new SNOMED concept, but that is what many of them have been looking for.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

So, a comment, well, I guess two comments. One is, I think the names of documents like this are much more complete in LOINC than they are in SNOMED. We already have the use case for LOINC codes for this kind of thing in the sense that in anticipation of the use in claims attachments, where you basically want to be able, in the claims attachments context you want to be able to say please send me operative notes, or please send me history and physical exam, or please send me all of the cardiac compensation notes. Those kinds of hierarchies have already been contemplated. They probably don't all exist in the way that they would need to be here, but I think the more I understand the use case it seems tidily tied to what we'd call "document ontology" an understanding of the kinds of documents or messages that can be exchanged and relationships of specific document types to classes of documents.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Let me just follow that. There are actually two rows here. One it says “Health Record Component,” which perhaps, as Jim has suggested, is not labeled as clearly as it should be because that’s really the document ontology and classes that would be the content of the communication that we’d be looking for, and we’d want to know that it is shared or sent or acknowledged. The one is the acknowledgement of it, or the sharing of it, and the other is what is the document. So using those to some existing ontologies, even though they may need some expansion to meet the needs, would make sense.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

So if I understand, and please correct me if I don’t understand, you would like things that said a discharge summary was sent or an electronic medical record summary was sent, or a consult note was sent, and likewise the same thing, that a summary was received or that sort of thing. I don’t think they exist in SNOMED or LOINC. They would need to be made to answer that specific use case, but I think the reference of knowing when you say a discharge summary was sent, it would be better to resolve what discharge summary meant against the LOINC code set and so you could set up the question in LOINC and then have it refer to the set of things that were discharge summaries in LOINC. I think we’re going to need new codes to meet this use case, and I would prefer to create them in LOINC rather than SNOMED.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Comments on Stan’s suggestion? It’s much easier face-to-face. Is that something that makes sense to people, to do the development of LOINC since the content of the communications are already in LOINC, or not?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I certainly support Stan’s suggestion.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, any other comments, pro, contra?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

We’ve been representing those things in SNOMED but I don’t necessarily have a preference. It’s just easier for me. I know SNOMED really well. But if others feel that LOINC is a better approach, we could support that.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I realize there is actually some representation in LOINC and some in SNOMED and for the existing content sometimes I can find it in one and not the other, but whatever the ongoing direction is we can certainly support that. What I’d also need to be able to do, though, is to indicate that something was transmitted or was acknowledged, so it’s the action itself that we need to be able to speak to, plus the content of what was transmitted. The action perhaps would also be LOINC, but I’d need to understand that.

Betsy Humphreys – National Library of Medicine – Deputy Director

I have been ... all of this, but with perhaps less subject knowledge than the rest of you put together I am really having difficulty envisioning exactly what these things are and exactly what terminology you need. Maybe the Vocabulary Taskforce needs to take this one on as well with a little bit more specifics so that those of us who are having difficulty following it, could follow it.

M

Sure. I can give you just a brief use case, if you’d like. It’s really to know that a patient with diabetes, the primary care physician has received a communication from the ophthalmologist who does the slit lamp exam indicating the results of the eye exam.

Betsy Humphreys – National Library of Medicine – Deputy Director

The thing is that my problem with this is I think I understand the use case but I'm trying to deal with this from the point of view of specific terminology as opposed to registration in the patient's record of these communications.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think Betsy has a good point, that this meeting has focused the question, and I think Betsy makes a good case that maybe the thing to do is to have the Vocab Workgroup then answer these questions, either LOINC or SNOMED, which is intrinsically structurally a more logical place to put it, is there anything to choose among resource, could it get done faster in one or the other. And if everyone else is okay with it I think it would make sense to hand this over to the Vocab team to answer those issues and provide us a recommendation back.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I agree with that. Could we have Floyd or somebody else representing the Quality Group just participate, because I think we're going to need to have continued clarification of the use case to do that properly.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I am on the taskforce, yes. The only question is for this Friday's meeting I may not be able to be there.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay, well I think we have enough agenda items for Friday's meeting. The other issue, of course, would be for the kinds of things we're talking about here it would be also useful to get some specific examples of those, for example, that have already been found in SNOMED or wherever they've been found.

Clem McDonald – Regenstrief – Director & Research Scientist

Could I just comment on the whole thing? I have trouble envisioning how it could even happen in real life actually. You send a mail, does that mean you've got to do everything by registered mail and then record the return to registry e-mail? There are a lot of issues mechanically and this could be a huge burden on practices if it isn't done at a practical level, if you really want to confirm they got it. Then you worry about if they read it, or if they really understood it. How do you do this when people are remote?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Clem, I don't disagree with your concern. I think that this may be, and we can certainly talk about that, more of a process oriented vestige of how measures have been done, and perhaps that might be an indication if it's that complex for implementation that measures should look more toward the outcome than the process that something was communicated, or perhaps the communication is confirmed by patient survey rather than otherwise. So I understand some of this seems very granular and it's really based on this one, what has been.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think maybe also based on what will be. A high performance organization has to keep track of this stuff. They have to know that so-and-so got their reminder about their mammogram and something happened or didn't happen, and then a letter was sent saying that it's normal within 24 hours, or someone's head gets cut off. While I think, Clem, you're right, how to execute it will be a problem and something that maybe it never gets executed entirely, I think organizations will benefit from having a standardized way of recording all of this and at least reporting it to themselves internally. But on the other hand, I can imagine that a reasonable quality measure would be that a patient gets notification of a mammogram result within 24 hours guaranteed documented and reportable.

Clem McDonald – Regenstrief – Director & Research Scientist

Yes, okay, that makes sense. I think what I had the trouble with is all communications and how you'd really manage that.

Betsy Humphreys – National Library of Medicine – Deputy Director

And anyway, this will be a good conversation for the Vocabulary Taskforce group because the more I'm listening to it the more I'm saying that what we need is a short list or maybe a long list of descriptions of

notification to whom, but then the rest of it is taken care of by the terminology you already have for mammograms or whatever it is.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right. So we will benefit from your gracious recommendation, Betsy, and move on to the next one. Thank you, great discussion, and a lot of work to do. Number four, condition diagnosis, problem both active and inactive. Floyd, are you going to talk about that one then?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes, this is to identify the current condition and in the context of a quality measure and inclusion of all patients with a certain condition, and that could mean all those who have a diagnosis such as diabetes, but it could also mean all those who have what might be considered a nursing diagnosis, such as those with gait disturbance that's not specific to any one diagnosis, to be able to include or perhaps exclude from a measure any people with those characteristics. So the presumption has been that it may be the problem list is the context of where it's found, but how do we represent it? I know in the past SNOMED has been considered and I know in HITSP the nursing terminologies that are in SNOMED already were covered in that way, but this is to not just billable but conditions and problems that are associated with the patient.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Is there any reason not to recommend SNOMED CT for this category?

Clem McDonald – Regenstrief – Director & Research Scientist

No, but I'd like to take your call and raise you one. Couldn't we just get findings and symptoms all done at once? They're all problems, can't we just lump a lot of these? It's all going to be SNOMED. We were talking about defining it as an assertional statement as So I don't think it's a problem. Problems cover all of that already.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes, I think you make a good point. The team has been talking about that, we wanted to keep the categories the way people have been looking at them for simplicity and maybe, well, we just ran out of time. But I think you're right, symptoms function in many of the same ways and we'll get down to that. Any –

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

....

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I'm 100% in favor of SNOMED here. I wonder, do you want to get into any of the issues of how pre or post coordinated these representations should be? Because just saying SNOMED, any given disease could probably be represented two or three ways at a minimum.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right, and I'm wrong more often than I'm right, but I'm guessing that for the scope of this meeting we just want to say SNOMED. I think we'd be thrilled if the Vocabulary Workgroup wanted to address that question, although I think that would probably depend on specific cases.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes, if you are interested in the Vocabulary Taskforce to look at some of the attributes we have, like severity and some of the others, where rather than use pre-coordinated terms in SNOMED we apply the qualifiers as attributes, we're happy to review that with the taskforce.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I think it's an important discussion, and it can work either way. But, yes, some of the things that are very nice to do by post coordination or especially if you're talking about if you evolve this into talking about procedures you can say whether this is something that's planned for the patient or whether it's already occurred, whether this is a rule out diagnosis, in other words a suspected diagnosis as opposed to a confirmed diagnosis, those things I think are very important in that understanding of these concepts in the concept of a quality measure and are often best post coordinated rather than pre coordinated.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right, and that's actually why we used attributes to do that, because in some of the ones we did last year we did have the concept of a presumptive diagnosis.

M

... come back to this HL7 segment for problems which I don't have memorized. If these conform we should try to stay with what's what. It's actually the RIM specification that we ... HL7 to do that underneath this.

M

But RIM doesn't give you the specificity that the segment gives you.

M

Okay.

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

We're dipping our toes into the information model issues again, and remember there was a whole term info notion of how to reconcile essentially equivalent ways of representing things in HL7 versus SNOMED composition. I submit that's a little beyond our scope today. I like the idea of letting the vocabulary sort this out, but I hesitate to say let's go ahead and add HL7 to SNOMED at this time until we clarify that post coordination, as Stan characterized it, isn't going to work.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great. Okay, I think for today we've done a great job and I think we definitely want to send this one to the Vocabulary Workgroup for their working out of those details. Let's go on to number five now.

Marjorie Greenberg – NCHS – Chief, C&PHDS

I'm back But anyway, this is being referred to Vocab, I guess, which I'm on, but again on the time frame, are we talking about Stage 3 here?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Pam?

Marjorie Greenberg – NCHS – Chief, C&PHDS

When are we talking about SNOMED CT being the only thing accepted for condition diagnosis problems?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. That's a good point, Marjorie. I thought that was MU 3. Pam, what is the –

Pamela Cipriano - ONC

I don't have –

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

... or whoever knows.

Pamela Cipriano - ONC

Jim, I apologize. I don't have the answer for that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Was it Aneed who had the answer before?

Pamela Cipriano - ONC

Anand. Yes, again, we were looking at all of these and as soon as we could come to a conclusion that the goal would be for any new measures being developed that they would conform to these conventions.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

That may be a good way to look at this, that by the time a guideline developer could respond to this recommendation it's hard to see how that could get into MU 2, that it would almost certainly be in

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well, just to throw a wrench here, I know that there are a number of subcontractors under CMS or ONC that are looking to create measures for Meaningful Use 2 in electronic format using this model with existing guidelines. So if they're going to and you need I-10 it would be important for them to know that.

Pamela Cipriano - ONC

Jim, we'll make sure that we ask Tom this question and provide clarity to both committees.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you.

Marjorie Greenberg – NCHS – Chief, C&PHDS

My only other point would be back to what Chris said right in the beginning of the call, that this last paragraph here under "Supporting Discussions" really should not just limit it to for billing purposes, but for reporting purposes for which aggregated data or a higher level of data is needed because –

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Absolutely.

Marjorie Greenberg – NCHS – Chief, C&PHDS

... that's much too limiting there.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I trust we got that as a principal in our notes that we will get that expressed correctly. Thank you. All right, number five –

Betsy Humphreys – National Library of Medicine – Deputy Director

Just to tell you, device terminology is not my favorite subject, as many people who know me realize, but in fact just to give you the background, the FDA has been involved for a number of years in the development with the international community of the global medical device nomenclature. If we could go for one for the purposes of regulation and activity, that's the one they would like to go for. As Chris pointed out, and others of you know, the current access arrangements to this licensing, etc., would absolutely preclude its use in the general healthcare environment. There are currently negotiations ongoing between the IHT SDO, which owns SNOMED CT, and the ... agency, encouraged, I should say, by the international regulators, including the FDA, to see whether this thing can be moved to a different governance and maintenance activity and perhaps be integrated as a section with SNOMED CT. I just give this all to you as background. My expectation is whether or not this will or does take place should be revealed to us by the end of this calendar year, which doesn't mesh very well with the requirement time frame for this activity. But I just give that to you as background.

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

I guess I'm more or less responsible for changing the draft recommendation from GMDS, or whatever it is, to the UMDNS, and I've had conversations with Martin Severs, in fact, just this week in Geneva, Betsy, and everything you say is exactly what he said. I think it's clear to everybody that if the intellectual property restrictions on the GMDS, or I can never remember that exactly, are mitigated, and certainly incorporation into SNOMED would be a way to do that for use in the United States, then it is clearly the

preferred terminology given the regulator consensus and investments that have been made in it globally. That being said, I think you've summed it up correctly, we're in a bit of a conundrum right now because the Meaningful Use recommendations I guess are expected imminently and I personally have a hard time recommending, as you said, a terminology that has severe intellectual property restrictions. On the other hand, given the likelihood that those will go away it's not a definite reality but it is a likelihood. I guess the question is do we want to gamble?

Betsy Humphreys – National Library of Medicine – Deputy Director

I don't know the answer to that. Of course the other issue is transition issues for anyone in the United States who may have already made an investment in the use of UMD&S because it's the only kid in the block at the moment.

M

And that's ... is the organization, is that not correct?

Betsy Humphreys – National Library of Medicine – Deputy Director

... that produces the universal medical bills.

M

Yes. And it's been free for ten years or so.

Betsy Humphreys – National Library of Medicine – Deputy Director

I regard this as a mess, which may get resolved soon.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

In terms of a recommendation that we need to make and understanding the dynamism you described, for today do we say UMDNS and the Vocabulary Workgroup keeps track of the negotiations and makes a recommendation for transition as soon as they have enough information to do it responsibly?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Can I just add something here?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

In our actually working with this last year in the 110 measures we worked on or so, in some cases we were able to actually find devices in SNOMED and use that. That's not to say that that's the correct answer from what I'm seeing here. So we can change to UMDNS but whatever we change to that gets into measures is what vendors are going to want to use to code their systems. We also found in some cases, and you can let me know if this is correct or not, the presence of a device that's indwelling is sometimes identified as a condition, that someone has a pacemaker in, rather than a pacemaker was inserted at some point in the So we look for

Betsy Humphreys – National Library of Medicine – Deputy Director

A question might be, given the level of information that is required in the short term about devices, whether if given, devices are not totally absent from SNOMED, but the level of specificity of devices that occurs in both UMDNS is much, much greater and is the level I think that is going to be more important going forward. But I suppose that another possibility for us to look at is what do you need right now for your measures and could we possibly ... within SNOMED and wait to see on this other thing?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes, that was the question. And in addition, what happens when even UMDNS or whatever doesn't have the device? Because I think our example when we looked at it in HITSP was the antithrombotic device, and I don't know that all of those actually exist in existing device terminologies.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that in every case it's sort of like what Marjorie Rallins said earlier, that if we know what it is and we know that they have a reasonable mechanism for adding them, then the fact that they don't have a particular one is less of a concern. We have to make sure that they can sufficiently add them. But I think that maybe it would be good, Floyd, if we could get a feel for what's the range of devices that we're going to need in the short term. It might be better to say if there's reasonable coverage of them in SNOMED, to go with that for now and not pick either one of these other horses at the moment.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

And the experience we've had, I don't know what's going to come up with new measures being developed, but the experience has really been pacemakers, catheters, whether urinary or ... and antithrombotic devices. I can't think of any others that we use as devices up until now. I can't say there won't be others.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Floyd, you're saying that thus far the device is ... in SNOMED?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well, except for the thrombotic ones, which I think got added or could be added –

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, obviously, the issue is when we're really dealing with patient safety what we need, in addition to this obviously, is the unique identifier is a device that's actually in the person and that ... is required anyway.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

And if the FDA goes forward with their plans, which they will, they're working on –

(Background conversation.)

Betsy Humphreys – National Library of Medicine – Deputy Director

I think somebody needs to use mute.

M

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

So at any rate, everything gets bumped to the Vocabulary Taskforce, right, so –

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Is this joint group prepared to say we'll recommend SNOMED now and ask the Vocabulary Workgroup to track developments and make additional recommendations as appropriate?

M

Well, there's the question about meaningful use and how constrained their uses are, I mean, the Quality Workgroup, so to you, Floyd, won't you be looking at surgeries too to infer the device? And there is this device, this aortic aneurysm rupture and there are rules about doing echos, if they already had one maybe you wouldn't do it, has that rule come up?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well, there are resource use measures and overuse measures, but I haven't seen them yet to know that. I think the answer will be if the procedure itself has identified insertion of the device where we don't have to specify the device or removal of the device or –

M

You're going to have it in radiology too. The report will tell you in effect if they've put a coil in. Maybe we shouldn't even worry about this, since you're handling it. What's going to happen is that if people read this device category and think that's what's used for all fields, or it may, rather than where you want to track a particular breakage or something you need a whole different sort of structure.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right, and I think that may be a little more future when this gets defined. The major one was for someone who has an implanted device or item. But even for the hip and knee replacement it's been the procedure not the device that has been used and we can continue to do that.

M

If we can finesse this, is what I'm really saying somehow might be our best bet, just saying not deal with it because you don't really have a specialized need for a device as a device yet. You're getting by.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

... I can see types of joint prostheses and comparing one to another and then we will need that.

M

Yes, I think if you're really talking about devices in toto you need a whole big device nomenclature, because there's lots of stuff that can go wrong, and for tracking and for safety and all these other reasons, but that's not what you're doing now. You don't have to prepare for everything right now. I suggest we maybe drop this, unless you need it to be named that way.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Since what we're trying to do at the QDM is think towards the future, rather than the word "drop" can we put "temporarily ...?"

M

Sure.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Is there a reason we wouldn't say "SNOMED CT" so if someone did need one they use SNOMED to do it?

M

There's no reason not to say that. It's just that for their purposes they're finding a device wherever they can, in ... and in devices and in problems and in surgeries. So, yes, it's going to be SNOMED CT for those too.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes, that way at least there's something there and some – I don't know, it might be fine just to say find it elsewhere, but it seemed to me that if we said that then we haven't changed anything and we haven't added any extra work to anybody. But if someone needed a device that didn't exist they could put it in.

Marjorie Greenberg – NCHS – Chief, C&PHDS

I agree with that. I think the level of our need right now, SNOMED has supported that. And, Floyd, regarding those other devices that we just discussed, we submitted new concepts for that and I think we have temporary IDs.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Great. I think that it meets the needs for the next year or two.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Does anyone else have any contra to just saying SNOMED for now and having the Vocab team watch it for us?

Clem McDonald – Regenstrief – Director & Research Scientist

I'm for SNOMED for now, but it would be nice to keep our eye on this other thing because we need those big vocabularies I think for devices and to –

W

... there are many eyes on that other thing.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay.

Patricia Greim – VA – Health System Specialist, Terminology

I'm just thinking that selecting SNOMED now avoids the impact of recommending perhaps something that isn't freely available and that the impact of recommendation of something that's not freely available might even affect negotiations. So I'm in support of the SNOMED suggestion.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Is anyone opposed to the SNOMED suggestion? I think if we can do ... it would be good to have some wording that says this is often found in CPT codes for the procedure or the problem list in other areas besides, so that if that isn't obvious to everyone they would understand that that may be the way that they want to address it.

M

Good idea.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

All right, and this is Jim, and number six, non-laboratory diagnostic studies. Floyd, are you –

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Sure. In trying to describe this from the perspective of the general clinician, one could say all procedures include lab studies, imaging studies and anything else one might do, but to help to sort it out to say these are basically imaging and non-lab procedures. So they could include an EEG, they could include a neurology lab where there's an electromyogram, and they could include an EKG stress test, but also all imaging procedures. It was separated this way to differentiate that from laboratory where it's specific lab ..., chemistry, microbiology, etc.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, then for the draft recommendations, Stan, is this another place where the LOINC would be added to SNOMED?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

So –

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Did you say no?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Well, I didn't say anything.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Oh, sorry.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Somebody else whispered something.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I see.

M

I do know that there are imaging procedures in LOINC and what was not clear was what is the right thing. For lab the observable was LOINC and the result could be SNOMED was what generally was discussed in the past, but what would we use for these non-lab diagnostic procedures.

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

This is a question, I guess for Marjorie Greenberg. How rich is ICD-10 PCS for non-surgical procedures?

Marjorie Greenberg – NCHS – Chief, C&PHDS

It is principally for surgical procedures, but I'm not an expert on the ICD-10 PCS. I can certainly find that out for the Vocabulary Workgroup, but I would have to check that.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

The other thing I should say is there are some kind of gray zone areas where it might be a CT with catheter guided insertion of ... into a cancer, and is that actually more of a procedure or is that an imaging study? So we need to identify what terminologies, what code sets we use for those kinds of things.

Betsy Humphreys – National Library of Medicine – Deputy Director

Floyd, am I not correct in that part of what we're trying to cover here are the standard imaging studies, I mean, imaging studies that are just done on thousands of people every day?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

That's right.

Betsy Humphreys – National Library of Medicine – Deputy Director

X-rays, ultrasounds, whatever.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right. EKGs, stress tests added into that, yes, that is

M

For the record, LOINC has about 4,800 radiology codes and it's probably got another 3,000 from an effort with DoD, all based on empirical review of actual master test files. They, however, do not distinguish, except maybe as an attribute, between imaging then for a procedure and imaging done for pure diagnostic purposes, that is, they're all in the same list. You can order placement of a catheter, placement of this or placement of that, and insertion of this and insertion of that. So that's just for the record.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Let me just say two of the measures we have, and I think some others coming in, are looking for longitudinal measurement of radiation dose. So we would need, whether it's for placement of catheter or just routine x-ray, a standard way to represent those.

M

That's a more complicated problem because it depends on a lot of things, after the name of the test or the name of the –

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

No, that I agree. That's another attribute we would have to deal with. But at least so we know what the test is

M

Clem, for the non-radiology, for all of the neurology tests and spirometry and EKG, all of the tests that are purely diagnostic that produce sometimes a picture, a cartoon or a graph or something or a set of numbers and interpretation, does LOINC have the capability to manage those sorts of test results?

Clem McDonald – Regenstrief – Director & Research Scientist

LOINC loves measurements, measurements are us, maybe, and cardiac, echo and EKG, and obstetric ultrasounds specifically, there are hundreds and hundreds of measures that are included in LOINC. I can't say it's true for every single physiologic measure, because they really are legion and it's dependent on people asking for them. But there are names for EMG, EEG, now electronystagmogram, I don't believe we have numeric measures submitted for those tests. It's peculiar that amongst the imaging world the cardiologists and the OB people tend to record numbers not just narrative text as part of their report.

M

So then my question is, why is LOINC not in the draft recommendations?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

I can answer that question. This is Marjorie Rallins again. Can I just offer some sort of practical, and I speak from practical experience of specifying measures, and diagnostic tests, ... tests, and surgical procedures, we represent those in SNOMED. Then the laboratory procedures we use LOINC and we use SNOMED for the values of those. I think this is similar to our previous discussion for simplicity sake, and what we, and, Floyd, you can weigh in here, what we do now I think SNOMED and LOINC work.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes, and, Marjorie, that is what we've been doing. That's why I was looking for what is the appropriate way to handle this, and that's why I'm looking to the committee, right.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Is anyone on the committee uncomfortable then with, have reasons that we shouldn't have SNOMED CT and DICOM as the recommendations?

M

To answer your first question, I think it was a mistake that they left LOINC off. DICOM actually, for all of its good things, I don't believe it specifies the procedure at a level anywhere near it. It has a code for the modality, was it a CT, MRA, MRI, they have text place for naming the procedure, they don't have a code, I don't believe, but I'd love to be corrected, for detailed procedure level. So I don't know where that came from. LOINC is used for non-lab in a lot of places.

M

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

I guess the issue that we have to find out is, unless somebody here on the call knows, whether it is correct to say that DICOM has a standard terminology.

M

They do, but I don't think it covers the spectrum of procedures. There is, as you know, Betsy, the ... that might be proposed to cover that space.

Betsy Humphreys – National Library of Medicine – Deputy Director

You've been using DICOM now, is that it?

M

No, we have not. This was added in as a recommendation from the recent work Accenture did.

M

DICOM has actually requested LOINC codes for some areas. But I haven't looked at it intimately in the last two or three years. But if you look at their manuals, they have lots of discreet measurements for lots and lots of things about the radiation dose and the ankle injection and the modality, but not for what we'd call the orderable report named procedure. There is a text field for that. We did lots of work at Indiana trying to match up stuff with real codes.

Betsy Humphreys – National Library of Medicine – Deputy Director

I'm so long out of this. I seem to recall DICOM, I regarded it as a message transport thing and that certain parts of it were going to be ... using LOINC and also SNOMED in terms of what they were looking at. But I haven't seen it in a long time, so I think maybe we had better get somebody ... or ... within the Vocabulary Taskforce

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, thank you, Betsy. We'll hand this off to Vocab and have them answer that. I think the question is what is the smallest set of code sets that would be adequate to meet the need?

Daniel Vreeman – Regenstrief Institute – Research Scientist

Yes, within the DICOM ..., I was looking at the content mapping recently, this is Dan Vreeman, there are specific things that reference the document title and refers to the LOINC document codes for such things.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It's on page what?

Daniel Vreeman – Regenstrief Institute – Research Scientist

Page 703, no, it's an extract, so –

Betsy Humphreys – National Library of Medicine – Deputy Director

We'll take a look.

Daniel Vreeman – Regenstrief Institute – Research Scientist

Take a look, yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

They're referring to LOINC and maybe saying DICOM is how you guys incorporated LOINC without knowing it.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Heather Stevens - Accenture

This is Heather. During our Friday discussion we knew LOINC might come up. It was just I think we erred on the side of having fewer recommendations than more, but we knew ... and it would make sense.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay.

Heather Stevens - Accenture

... from our Friday discussion.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, number six goes to Vocab, and now we're on number seven. Floyd, is there any reason, or, Heather, is there any reason that it wouldn't be SNOMED, can we just throw this open to the committee for reasons not to use SNOMED for encounters?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think encounter's a structure, so I have trouble understanding what the content is being described.

M

What we're actually looking for is interaction between the clinician and the patient. It's not limited to a physical encounter.

Betsy Humphreys – National Library of Medicine – Deputy Director

So this, it seems to me, is very analogous to this communication thing we were dealing with.

M

Right. It actually is, this is a little more of a physical, I shouldn't say physical, but it's traditionally been applied to you've had a visit with your physician and if the measure developers allow a test tell them that it's a visit and it's allowable. But, yes, this is similar to communication in that way.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes, that was you, Betsy, this is Jim. I think you have a good point, that what is really at issue is communication. It's always been face-to-face in an office, or traditionally, but that's precisely what is changing.

Betsy Humphreys – National Library of Medicine – Deputy Director

The whole thing about this is, and again maybe we should, Jamie is going to be very irritated as I keep getting more work for the other group. But the thing is that it seems to me, again, I'm having such a problem with this, what is the terminology we need to record these, as opposed to just the fact that it's in my records, I visited the doctor on Friday. Then there's the issue of well, what happened during the visit? Fine, then we can say, well, you can have terminology that we already have to say that I got my shingles vaccine or whatever. But I'm having real trouble with the whole issue around this in terminology as opposed to a recording of certain messages going back and forth. I don't know.

M

... actually part of our use case issue has often been about accountability. So if a physician, for instance, didn't see the patient until December 1 and they were expected to treat the hypertension and expect improvement within so much time afterwards, it was expected that the condition was known prior to seeing the patient. Now in an accountable care organization measure that might be somewhat different because it's not an encounter, they're responsible for the patients overall. But that's where this comes up, is there had to be some kind of foreknowledge before you'd be expected to do something.

Betsy Humphreys – National Library of Medicine – Deputy Director

Of course this definitely deals with this whole model of how we're representing, this information model, but I ... which of this really translates into a terminology problem.

M

Right. Floyd, this almost sounds like you may have one question you have a series of answers for, but you just haven't listed them here. Then it would be easy. But if this is the whole world encounters it's so ephemeral that it's either a whole data structure with a lot of fields, and there are such messages, but I almost think you've got to list the names in here. If you go back to the committee and say you don't want to have this question with these 20 answers, or this field with these 20 answers, but is it setting you're looking for, is it the type of encounter?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is type of encounter and then the setting can be separate. But, yes, you're right. I understand.

M

So you can make a list and we can just decide.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Well, I think it's very analogous to the one above and I think it should go to vocabulary to discuss. If I heard in there, too, Floyd, you care about the dates and things, and so I'm seeing this almost, Clem, as a

panel that would say, you know, encounter summary or something. That's probably the wrong term, but it would say kind of encounter, who's the clinician, what was the date and time, that sort of –

M

Part of HL7. This goes back to what Betsy says, this is not a vocabulary issue –

M

Right.

M

... talk about encounter types or reason for encounter or explicit fields within that. But as it stands it's clearly a message type or an information model.

M

Yes.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

I completely agree with that. I would also, I don't know, Floyd, if this is your issue, but again the language, the word "encounters" means different things to different groups, and the measure developers, if they see this category, will automatically connect this with a CPT code or an ICD-10 PCS code unless we really clarify what we mean here.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It sounds to me like we have consensus that communication and encounter, which is probably better titled "interaction" or something, but the two of those together go to Vocabulary to address what, although Floyd I obviously will need to help with what precisely is in view.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think the other thing that will help is these are the higher level categories and so to kind of work through the model that we've worked on, much of it based on HL7, to be able to express what we're looking for and to give you exactly what we need, rather than just a higher level concept here.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Jamie and Betsy, I'm sorry. I hadn't anticipated that quite so much of this would be handing off to Vocab. But I do think the meeting's been useful to get clear what we understand and what we don't and maybe Vocabulary will have a lot clearer sense of what the questions to it are, I hope.

Betsy Humphreys – National Library of Medicine – Deputy Director

Jim, I think our time is up shortly.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

I believe this is a public meeting and we should give an opportunity for public comment.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right. Judy, are you –

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, I'm here.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Can we have that for the last five minutes?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, that's fine. Do you want to do it now?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes, unless anyone has one or two minutes summing up that they want to do that would either help us, I mean, I guess quickly I would say that it seems to me that it would be worth having another joint meeting that we really need both groups together to do that. Does that sound reasonable to people?

M

Yes.

M

Yes.

W

It does to me, yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

All right, then we'll do that, and, Judy, then, if you would open it to public comment, please.

Judy Sparrow – Office of the National Coordinator – Executive Director

Sure. Operator, can you please check and see if anybody wishes to make a comment. Operator?

Operator

We have no public comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, operator. Thank you, everybody.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Judy, just one moment. I'd just like to really thank the joint team and the team that put this together. This is remarkably difficult and I think it was a really valuable session, so thank you all.

Judy Sparrow – Office of the National Coordinator – Executive Director

All right, thank you.

Public Comment Received During the Meeting

1. I would like to make a comment re: snomed for clinical documentation. Although I agree with the concept that quality reporting should be a byproduct of the EHR you need to take into consideration the complexity this adds to physician documentation and physician adoption of electronic documentation. Physicians do not currently use SNOMED terms as a standard practice in their documentation. Will the committee consider allowing for some components of the quality reporting to be "abstracted" by quality department if physician documented in free text?