

Clinical Quality Measures Workgroup and Vocabulary Task Force
Draft Transcript
June 29, 2011

Operator

All lines are bridged, Ms. Sparrow.

Judy Sparrow – Office of the National Coordinator

Thank you, operator. Good morning everybody, and welcome to a joint meeting of the Clinical Quality Workgroup and the Vocabulary Task Force. This is a federal advisory call, so there will be opportunity at the end of the call, around 11 o'clock, for the public to make comment.

And let me do a quick roll call – Jamie Ferguson?

Jamie Ferguson – Kaiser Permanente

Present.

Judy Sparrow – Office of the National Coordinator

Betsy Humphreys?

Betsy Humphreys – National Library of Medicine

Present.

Judy Sparrow – Office of the National Coordinator

Clem McDonald?

Clem McDonald – National Library of Medicine

Present.

Judy Sparrow – Office of the National Coordinator

Stuart Nelson?

Stuart Nelson – National Library of Medicine

Present.

Judy Sparrow – Office of the National Coordinator

Marjorie Rallins? Stan Huff? Chris Chute? Marc Overhage? Dan Vreeman?

Dan Vreeman – Regenstrief Institute

Present.

Judy Sparrow – Office of the National Coordinator

Floyd Eisenberg?

Floyd Eisenberg – National Quality Forum

Present.

Judy Sparrow – Office of the National Coordinator

Donald Bechtel? Patty Greim?

Holly Miller – Department of Veterans Affairs

Holly Miller for Patty Greim.

Judy Sparrow – Office of the National Coordinator

Holly, thank you. Chris Brancato? Andrew Weisenthal? Bob Dolin? Ran Sriram? Ken Gebhart?

Ken Gebhart – National Institute of Standards and Technology

Present.

Judy Sparrow – Office of the National Coordinator

Lynne Gilbertson?

Lynne Gilbertson – National Council for Prescription Drug Programs

Here.

Judy Sparrow – Office of the National Coordinator

Nancy Orvis? Marjorie Greenberg?

Marjorie Greenberg – Centers for Disease Control and Prevention

Here.

Judy Sparrow – Office of the National Coordinator

Karen Kmetik? David Baker? Anne Castro?

Anne Castro – Blue Cross Blue Shield of South Carolina

Here.

Judy Sparrow – Office of the National Coordinator

Let's see – Bob Dolin? Did I say – no. Gene Nelson?

Gene Nelson – Dartmouth University

Here.

Judy Sparrow – Office of the National Coordinator

Eva Powell? Phil Renner? Danny Rosenthal?

Danny Rosenthal – INOVA Health System

Present.

Judy Sparrow – Office of the National Coordinator

Joachim could not make it. Rosemary Kennedy?

Rosemary Kennedy – Thomas Jefferson University

Present.

Judy Sparrow – Office of the National Coordinator

John Derr? Tom Tsang?

Tom Tsang – Office of the National Coordinator

Here.

Judy Sparrow – Office of the National Coordinator

Pamela Cipriano?

Pamela Cipriano – Institute of Medicine

Here.

Judy Sparrow – Office of the National Coordinator

John White?

John White

In the house.

Judy Sparrow – Office of the National Coordinator

Aneel Advani? Patrice Holtz? Did I leave anyone off?

Asif Syed – American Medical Association

Asif Syed.

Judy Sparrow – Office of the National Coordinator

Asif, thank you. And with that, I'll turn it over to Betsy Humphreys.

Betsy Humphreys – National Library of Medicine

Hey everyone. When last we spoke on the subject, we had – we were working through our way through the spreadsheet and we had discussed items 1 through 7, which puts us at #8 -- Experience.

Clem McDonald – National Library of Medicine

Betsy, could I just clarify the document that got sent out? Does that represent any of the discussion, or is that still a 2009 document modified?

Betsy Humphreys – National Library of Medicine

That's the original document that you looked at at the last call. There are no changes.

Clem McDonald – National Library of Medicine

Okay.

Betsy Humphreys – National Library of Medicine

So we are now at item #8 on this, which – Experience.

Clem McDonald – National Library of Medicine

Well, you know, we talked somewhat about these things are sort of characterized in a non-optimal way, in that these would typically be survey instruments or questionnaires of some kind; and the answers might be Likert Scale or they might be some specific descriptors and they just don't fit the – so anyway [interrupted]

Floyd Eisenberg – National Quality Forum

Okay, so this is Floyd. And I don't disagree with that. I think the issue is we need to be able to express Experience and if that means it is a validated survey or instrument and that's what we're able to address, and that might be an instrument in LOINC that would be fine. So that works.

Clem McDonald – National Library of Medicine

I thought you were gonna get us some of the – sort of the background documentation, and maybe you did and I missed it.

Floyd Eisenberg – National Quality Forum

Well, actually there was – this is a subset of the full technical specification of the QDM. And I thought it had been sent out to the Clinical Quality Workgroup. I don't know if it went to this group. But that has more of a background and actually more of the model than just the categories that we're dealing with here. But unfortunately, experience is somewhat limited in its scope because we haven't really identified, except for tools, what kinds of information will be needed to determine patient involvement in care.

Clem McDonald – National Library of Medicine

Yeah. There is a lot of – I mean there are a lot of survey instruments that are out there. I don't know if there is – the one that's been chosen or anointed.

Betsy Humphreys – National Library of Medicine

Well, so the issue here is – Floyd, am I following you correctly? Depending on which measure we're dealing with, patient experience may be one of the things that's measured or may be the thing that is being measured.

Floyd Eisenberg – National Quality Forum

Yes. And it may be their experience had the result, so if there was a scale. And depending on -- you want only those with bad experience to look at your inclusion criteria. You would identify that how? And I would agree with Clem right now. Unless you are using a tool to identify that, or some instrument, you wouldn't – there is no discrete elements that you would really know what to pull in. And the measure developer would identify the evidence for which instrument or tool works and has been validated to provide that information.

Tom Tsang – Office of the National Coordinator

So Floyd – this is Tom from ONC. Can you just use a real-life example, so for example the PHQ-9 screening?

Floyd Eisenberg – National Quality Forum

Yeah, so – and that actually works. PHQ-9 is actually more -- I guess I would call it a Depression Risk **Scale than** Experience, but that fits and actually is in LOINC, as is every component of the scale. AVR-12 might be one here for Functional Status. These are all similar and [interrupted] ...

Betsy Humphreys – National Library of Medicine

So from the point-of-view of vocabulary, which is what we're focused on here, I would think that we could say that from you know the standards perspective, that we would be recommending that LOINC would be the standard for the assessment inst – for identifying the instrument and the questions within the instrument and where appropriate SNOMED-CT would be the standard for the answers that the person – that the patient would give. And I would certainly think that we as the measure developers focus on this and say okay, well here's the assessment instrument people are going to be able – should use, then it would then become a priority to incorporate any of those that are not already in LOINC, in LOINC.

Floyd Eisenberg – National Quality Forum

Right. And so I think that would fit well with two caveats: One is, as we move into future measurement concepts, there may be something in addition that we need beyond that. Which, we don't know what that is yet. So we can only deal with what we know. But, the other caveat is many of the instruments are proprietary and require some licensing with cost. And that's more of a policy issue but is something to be considered.

Clem McDonald – National Library of Medicine

Well, I mean that's actually I think an effect of inadequate attention on the part of – well period. I won't get into details. But LOINC has some license -- PHQ-9 is copyright. It does not require a fee for its use, and they gave LOINC permission to distribute it. So I think the thing to do is try to avoid those that have an onerous burden on them wherever they're used. That's just something for us to keep an eye on going forward.

Floyd Eisenberg – National Quality Forum

I would agree. It's more of a policy kind of issue than it is a standards issue. Right?

Gene Nelson – Dartmouth University

This is Gene Nelson. An example of an instrument that would be experience might be the CTM-3, the Care Transition Matrix-3 items. And that would be straightforward and it's analogous in the way it's used to a PHQ-9 in terms of the way its scored. It's a simple three items in its score. But let me just raise this question. If we were to use a patient reported measure, and it could be experience-based or it could be health status that used computer-adaptive testing such as the PROMIS measures from NIH on health

status, some of them are fixed scales on PROMIS ten-item survey. But more powerful and in the future would be dynamic assessment based on computer-adaptive testing. Would the PROMIS kind of patient report invoking computer-adaptive testing – does that fit into this frame?

Floyd Eisenberg – National Quality Forum

So my answer would be absolutely. In fact, here at NQF there has been a lot of discussion about looking at PROMIS for this purpose. We've heard that from our National Priorities Partnership, from the Measures Applications Partnership, and I think we've heard that from a number of other sources. So the question then is: Does that suggest that the PROMIS instruments would require a LOINC code?

Dan Vreeman – Regenstrief Institute

This is Dan Vreeman. Actually all of the PROMIS items, including the collections into item banks and short forms are actually already in LOINC. We did that part of the last release. So we got it.

Floyd Eisenberg – National Quality Forum

So it sounds like that's just what we need. Let me just say, I think that this is where Experience, some of the Functional Status, and Risk Evaluation categories all I think could be covered under this patient-reported data, actually is what we're looking at.

Marjorie Greenberg – Centers for Disease Control and Prevention

Okay. This is Marjorie – on that – Marjorie Greenberg. I'm not used to being on – this is the only call I'm ever on where there are two Marjories. In any event, you're having said that, it makes me wonder – cause we haven't gotten down there yet – but in a few items we get to functional status and ICF is invoked. And I'm wondering if you're describing or defining experience so broadly to include outcome measures, etc., if the statement that there is no need for retrieval of data for secondary data use, hence no need for ICD-9 or '10-CM and I guess anything other than SNOMED-CT is what implied here, if that is really a statement that is correct or appropriate. I mean if we are talking about their experience with care, I would agree. I don't feel as though things that are captured in the internet [distortion] patient satisfaction with care or whatever. But if you're getting into outcome measures, functional status, other symptomology or whatever, unless we've made a clear-in-the-sand decision that it will only be SNOMED-CT for anything – and we won't consider the International Classifications -- then I question this statement.

Clem McDonald – National Library of Medicine

Marjorie, I think that this has connect confusion, but there is a blending of the views of the world as being everything can be characterized by a single descriptor or phrase. And what the experience discussion we just had says mostly these are survey instruments of some kind or multiple-choice questions which apply just as well to functional status. In fact, that's where most – how most of those are defined.

Marjorie Greenberg – Centers for Disease Control and Prevention

Yes.

Clem McDonald – National Library of Medicine

So I'm agreeing with you. And I think that the general category would apply to these. And I think the issue of descriptors such as ICD-9/ICD-10 is a separate dimension, or ICF, and where they should be used or when they should be used.

Marjorie Greenberg – Centers for Disease Control and Prevention

True, but then I'm questioning this statement under Supporting Discussion.

Clem McDonald – National Library of Medicine

Well, this is old. This is a 2009 discussion, I think. Doesn't represent today's –

Marjorie Greenberg – Centers for Disease Control and Prevention

Well, and I'm also questioning the Draft Recommendation I guess as being LOINC/SNOMED-CT. I mean I think it is relevant to this discussion, unless I'm on the wrong track here.

Clem McDonald – National Library of Medicine

Well, are you still on 8?

Marjorie Greenberg – Centers for Disease Control and Prevention

Yeah.

Floyd Eisenberg – National Quality Forum

Well, I think Marjorie is responding to my comment that this is similar to the other issues. One thing I'm concerned about – this is Floyd – is: Where did the concept that this is a 2009 discussion come from?

Clem McDonald – National Library of Medicine

Well, I may have misstated. But the document from the workgroup 20-August-2009, has – it really is the same structure and has much of the same content. The recommendations are old. There may be some additional columns.

Floyd Eisenberg – National Quality Forum

Cause what I opened up was something from June 21st of this year that we created.

Clem McDonald – National Library of Medicine

No. If you went back, you will find the exact 23 very, very similar parallel.

Betsy Humphreys – National Library of Medicine

Well, it doesn't matter what age it is at this moment cause we're discussing this document in front of us. And I think that the question that I would – what Marjorie is saying is that in some cases the answers to – or the patient-reported experience, it would be legitimate likely whatever for it to be reported using one of the classifications. Is that your point?

Floyd Eisenberg – National Quality Forum

Yes.

Betsy Humphreys – National Library of Medicine

And I guess it would depend which classification, I mean which instrument we're talking about.

Floyd Eisenberg – National Quality Forum

Yes.

Betsy Humphreys – National Library of Medicine

So, I think you don't want a categorical statement that we would never be reporting these things using ICD-10-CM or whatever. But I think we would have to look at the individual instrument that was chosen for a particular quality measure to determine whether that was true for that one or not.

Floyd Eisenberg – National Quality Forum

I agree completely, but I was questioning the categorical statement here.

Betsy Humphreys – National Library of Medicine

Okay. I think that we probably have done as much damage to that as we need to.

Floyd Eisenberg – National Quality Forum

Okay. I just wanted to [interrupted]

Betsy Humphreys – National Library of Medicine

No, I don't mean you [interrupted]

Jamie Ferguson – Kaiser Permanente

This is Jamie. My two bits worth on this is I like the idea of using LOINC to identify the survey instrument, and I agree that the descriptors of ICF may be appropriate for the – for functional status. But I don't

agree that the ICD-9 or '10-CM should be used in place of SNOMED to describe the clinical items. So I think, you know, we should have a – we do have a preference for using SNOMED and then translating to the billing codes when necessary, rather than when there is [interrupted]

Betsy Humphreys – National Library of Medicine

As long as we stop using that term “billing codes.”

Jamie Ferguson – Kaiser Permanente

Well, if there is a [interrupted]

Betsy Humphreys – National Library of Medicine

It causes me pain.

Jamie Ferguson – Kaiser Permanente

Well, if there is a chance of picking an instrument that would use SNOMED instead of the classification systems, then we should do that.

Karen Kmetik – American Medical Association

This is Karen Kmetik. I just wanted you all to know that I joined. And just in response to those last couple comments -- and I'm sorry if I'm off track cause I missed the beginning – but I'm just wondering at the end when we have our set of recommendations if it's worth just adding some footnotes about the mappings that are available for mapping say SNOMED to these other code sets, be it ICD, CPT, what have you, just to let folks know in the transition phases those maps are available.

Betsy Humphreys – National Library of Medicine

I don't see why not, if they are available by the time we publish this.

Clem McDonald – National Library of Medicine

Betsy, now that we've gotten into the discussion, could be still assert the rules would probably apply the same to experience and functional status, however they evolve.

Betsy Humphreys – National Library of Medicine

Yeah. I am waiting to discuss functional status, or we can discuss it now. I mean to my way of thinking, it seems that the International Classification -- the ICF – Marjorie, as far as I understand it, is in a parlous condition at the moment.

Marjorie Greenberg – Centers for Disease Control and Prevention

Is it – in what?

Betsy Humphreys – National Library of Medicine

I mean it's – as I understand it, it is not in a well-maintained or [pause]...

Marjorie Greenberg – Centers for Disease Control and Prevention

No, I would – I would disagree with that.

Betsy Humphreys – National Library of Medicine

Okay.

Marjorie Greenberg – Centers for Disease Control and Prevention

I absolutely disagree with that.

Betsy Humphreys – National Library of Medicine

Alright.

Clem McDonald – National Library of Medicine

Well, I mean to clarify, there is nothing on earth that would prevent databases or systems to have a field or a question called ICF Functional Status, or multiples because it's sort of a – it's got a couple pieces to

it. Most of the classic functional scale instruments are Likert Scales, and they don't have either things that look like ICD-9, SNOMED, or ICF answers to them. So ICF --ICCF is sort of a summary statement, and I don't think we should exclude it. But you won't see it in Karnofsky Scale and you won't see it in these things that ask people six or eight questions and they usually rank from 1 to 5 on what their answers are.

Betsy Humphreys – National Library of Medicine

So, I think where are – where I believe we are with this is that a general strategy is LOINC for the questionnaires for the assessment instruments and in many cases SNOMED for the answers if, depending on the particular instrument ICF is appropriate, then that would be fine.

Floyd Eisenberg – National Quality Forum

I maybe would suggest one slight modification. And I think you might want to say, I mean – you might want to say LOINC for the observation because in some of these areas, what ICF is good at is representing a summary classification for say somebody's ability to walk. But in order to assign that qualifier – the thing – the sort of summary statement about that – you might do a variety of things. You might assess them with a specific instrument. You might make a gait-speed velocity measurement. You might do observation on gait analysis. And you would roll all those things up into that summary classification. So, you know it's not just – it is [inaudible] instruments, but it's also specific observations or measurements as well.

Betsy Humphreys – National Library of Medicine

Okay.

Floyd Eisenberg – National Quality Forum

And so I think it's very difficult to craft a specific statement about which terminology for which, because it's sort of a woolly area, as Clem likes to say.

Betsy Humphreys – National Library of Medicine

Okay. I think that's a good comment. And we now move to Family History.

Marjorie Rallins – American Medical Association

This is Marjorie Rallins. I just wanted you to know that I joined late.

Betsy Humphreys – National Library of Medicine

Hi Marjorie. So [pause]...

Floyd Eisenberg – National Quality Forum

Just to give a little context: In the past when we dealt with this in the Quality Data Model, we looked at the condition and applied the LOINC code of the context Family History. But in most clinical records, the family history is a separate section; and there are actually are concepts in SNOMED and elsewhere specific to Family History. So, we have a lot of comment that this should be a separate category of information.

Clem McDonald – National Library of Medicine

Well, one could also conceptualize this as a survey instrument or questionnaire. And then – and they are conceptualized differently in different – You know how we've got the Surgeon General's Family History, there is the Kevin Hughes' HL7 [indiscernible] Family History, which have slightly different models and the questions are different. But you end up with things like: What's the disease? -- which in that case I would suggest it be SNOMED. But it gets blended, you know. And you have something saying: Who's the relative and the relationship? And that's probably SNOMED too. But the field isn't quite crystallized to one model -- you know to make this explicit. I mean is anyone – do you – you know closely familiar with the Surgeon General's. There is like maybe ten questions with the answers being mostly things like the condition names and the relationships – you know, like the cousin and uncle and aunt.

Betsy Humphreys – National Library of Medicine

That – and I know that the current version of that has SNOMED in coding.

Clem McDonald – National Library of Medicine

Yes.

Floyd Eisenberg – National Quality Forum

So I think – this is Floyd – I think what I'm hearing is: There are attributes or a model and within that there are the ten components you talked about, so it's the relationship, etc. And that is – we don't have all those attributes built in but certainly can do that, and especially if you're giving us a direction of where to find them on the model, if there is – but you're also saying it's not a standard model.

Clem McDonald – National Library of Medicine

Well, it's just – there's disagreement at the level of detail collected, ranging from: I want to know that my aunt had – you know there is -- a first-degree relative had breast cancer versus the Surgeon General's which is sort of in-between versus you want to make a full family pedigree which is like an hour task.

Floyd Eisenberg – National Quality Forum

Right. Well, so I think in the context of measurement, the main issue would be applying family history as a risk – that patient's risk for developing a condition, in which case it's often first-degree relative, but may answer a bit more. I don't think it would look for a full pedigree. But, others can comment.

Stan Huff – Intermountain Healthcare

Well – this is Stan. I have been on too just a little late, but there is an HL7 standard that provides the structure approved for messaging around family history. I don't remember us creating LOINC codes for all of those attributes, but I mean that's – the [indiscernible - status]. And there are working systems, including Microsoft Health Vault, that use that model. And so it's exactly as you described it, Floyd. There is an information model; and within that information model, then you can use the names of diseases that the patient has. And there are specific set of relationships that are allowed to say which person we are talking about, and all that sort of stuff.

Clem McDonald – National Library of Medicine

The Surgeon General model is represented as questions in LOINC with answers that would be SNOMED, I think in most cases. But just wanted to raise the question that there is some intensity in feelings about this, and they don't all agree on what level of detail the history should be taken in.

Betsy Humphreys – National Library of Medicine

But from the point-of-view of a measure, if the measure is defined as what they're looking for, then I guess the implementation of the measure will have to go against the model that's in use in that system. Right?

Clem McDonald – National Library of Medicine

Right, yeah.

Stan Huff – Intermountain Healthcare

So if the recommendation then would be perhaps the HL7 model and the appropriate terminology or code sets for each of the attributes within that, the question would be to make sure there is a LOINC code for each of those attributes.

Clem McDonald – National Library of Medicine

Yes. Just a slight clarification: I believe the HL7 model is actually the Full-Pedigree Model as it's implemented.

Stan Huff – Intermountain Healthcare

Oh.

Clem McDonald – National Library of Medicine

I think it's Kevin Hughes from Mass General who is – or one of the Partners places that is really the energy behind it. But yeah, I would agree with that.

Betsy Humphreys – National Library of Medicine

Okay, so a LOINC for the attribute, SNOMED-CT for the value. I mean, my assumption would be: If you're really going against existing records and you're talking about family history, that this is a place where the correspondence between mapping between SNOMED-CT and the classifications would be used, because I would assume that some of these data would have been collected already – right – using the classifications.

Clem McDonald – National Library of Medicine

Well, an awful lot of it's going to free text and current histories.

Betsy Humphreys – National Library of Medicine

Yeah. Okay, well then yeah. Alright, so we now have arrived at Functional Status. We already discussed it?

Floyd Eisenberg – National Quality Forum

I think so.

Betsy Humphreys – National Library of Medicine

Yeah. Now we have Health Record Component.

Floyd Eisenberg – National Quality Forum

So let me just – this is Floyd – add a concept here, cause perhaps the definition isn't clear enough. What we're really looking for is that a – something in the EHR has been used in order that there is a Discharge Summary, that there is a – and that it is shared, there is a Clinical Summary and that it is shared. So the actions on it would shared, acknowledged, and the like. But what we're looking for is that something is like a Discharge Summary, like a Med List, the Problem List; how to identify that section of the EHR.

Jamie Ferguson – Kaiser Permanente

So Floyd – this is Jamie – one of the things that occurs to me here is that it may be useful to define the scope and contents of the sections using something like the HL7 EHR System Model.

Floyd Eisenberg – National Quality Forum

And that's fine, because the main point here was to indicate that if you wanted to say a Problem List is updated and how often. I realize implementation of that isn't there today. But if that was intended, how would we identify the Problem List. So, we can certainly get HL7.

Jamie Ferguson – Kaiser Permanente

So I'm assuming that LOINC will be fine for – essentially for naming the components. But in terms of what each of those components – you know how it's defined – is there anything better than the HL7 EHR standard?

Floyd Eisenberg – National Quality Forum

Are you talking about the Functional Model?

Jamie Ferguson – Kaiser Permanente

Yes.

Floyd Eisenberg – National Quality Forum

Yeah.

Clem McDonald – National Library of Medicine

Well, there is also the messages. So like problems are defined as specific – a bunch of specific elements. These are also mentioned in attachments very frequently. You know, please send me the “X.” And “X” may be the obstetrical record, it might be the Problem List, it might be the medication records.

Floyd Eisenberg – National Quality Forum

Yeah. We’re just looking for the advice of what to use. And again, the Functional Model can work, but I understand there are other mechanisms.

Betsy Humphreys – National Library of Medicine

Well, I mean the document – the record components, that would definitely be LOINC. Right?

Floyd Eisenberg – National Quality Forum

Right. I think Jamie was referring to defining them using the definitions of the Functional Model. But the components as a vocabulary would be LOINC. Is that what I heard?

Jamie Ferguson – Kaiser Permanente

That’s what I’m saying, yes.

Betsy Humphreys – National Library of Medicine

Yeah. So, alright that makes sense to me. But I mean if somebody says to me: “I need you to send the X.” They’re gonna take what I send them, right? Whatever I’ve defined it as that’s in that document.

Floyd Eisenberg – National Quality Forum

Right.

Betsy Humphreys – National Library of Medicine

I mean the fact that you define it doesn’t mean that that’s what they’re all going to be, right? Because of the structure of these items.

Floyd Eisenberg – National Quality Forum

Exactly.

Betsy Humphreys – National Library of Medicine

Although saying what you want would be good, of course.

Floyd Eisenberg – National Quality Forum

Well, this was intended as a start, indicating if especially we’re seeing in requests by policy committee and others for use of a Problem List or reconciliation of a Med List, just at least to be able to indicate that this – were talking about a med list; is really what – it’s fairly basic, but that’s what we were looking for, or that I’ve shared a Clinical Summary. What a summary is, the content – the term Clinical Summary we could look to LOINC. But what is the summary, the content of it? That’s also something we have to – so if we wanted to identify a C32 as the summary, where would I look for that on a vocabulary? Should that be a LOINC code?

Clem McDonald – National Library of Medicine

What’s C-32? Is this back to HITSP?

Floyd Eisenberg – National Quality Forum

Well, it is. But it’s a summary that’s often been discussed in many of the standards meetings.

Jamie Ferguson – Kaiser Permanente

It’s a Summary Record.

Floyd Eisenberg – National Quality Forum

It’s a summary record. Right.

Jamie Ferguson – Kaiser Permanente

Yeah, so I mean that ought to be a LOINC. Right?

Floyd Eisenberg – National Quality Forum

Yeah. Because then that would define the content that we need – that when we say summary as a concept, we would have a LOINC code. But which summary would also have its LOINC code, and that's saying the Summary Record. But if we were to say Discharge Summary as something separate, that would not be C32, it would be another.

Clem McDonald – National Library of Medicine

That actually has a LOINC code.

Floyd Eisenberg – National Quality Forum

It does. I agree. Cause we've used it in a measure. So, that one I'm aware of. But that's the difference. The one piece is to say: We are talking about a Clinical Summary as a concept, and they need a code for that. And then I need a code for which one.

Jamie Ferguson – Kaiser Permanente

So really, in order to use LOINC for this then, we'd have to have LOINC codes for the different templated sections of the Summary Record, in essence. Right?

Floyd Eisenberg – National Quality Forum

Yeah. I mean there is the slight nuance of saying this thing is a Summary Record versus saying this is a Summary Record that's conformant to X-template from C32. And I think it's a different attribute – you know saying what template this conforms to rather than saying it's a – you know but – rather than defining that by LOINC code.

Clem McDonald – National Library of Medicine

I mean this thing gets complicated cause on the one side, everybody kind of knows these words and they're using them in common usage today. And insurance companies ask for all these sections and get them at some level of accuracy. And then the second thing is: Changing the practice everywhere so that people do things in exactly one way. And I think the second thing is gonna be not a vocabulary-controlled thing. I mean it's something for the future.

Floyd Eisenberg – National Quality Forum

I either disagree it's for the future or the question is if it's something that has been – this is something that was identified as an area to be described for the future and that's why it's on the list.

Clem McDonald – National Library of Medicine

Well, I think describe all the words you just used and people would have an understanding. That doesn't mean they'd be definitionally computer-precisioned to be exactly one variant or another variant.

Jamie Ferguson – Kaiser Permanente

Yeah. I mean I don't think this is something that we're gonna solve with a magic bullet of adding certain codes today. At the same time, this isn't something for the far-off distant future – something that's discussed I think pretty, actually extensively in the last couple of Standards Committee meetings. For example, there has been a discussion about: What is a Problem List? When we say Problem List, does it mean anything that's thrown into the first page of the EMR, or does it mean really just disorders, findings, and situations? And actually for Problem List, both the Policy Committee input and the Standards Committee is tending towards the latter. But so that's defining within each of these components. And so if we're gonna use a vocabulary for defining the components, we ought to have the ability to use the standard definitions of those components.

Floyd Eisenberg – National Quality Forum

And that's exactly what we're looking for.

Clem McDonald – National Library of Medicine

Yeah. I would agree with all that, but I thought we defined all that. [laughter]

Betsy Humphreys – National Library of Medicine

Okay. So are we ready to move on?

Floyd Eisenberg – National Quality Forum

Can I just ask: What was the conclusion? I got a little confused with the subsequent discussion.

Jamie Ferguson – Kaiser Permanente

Well, I think it is LOINC. But I think LOINC may need to be enhanced to include things like identifying templated sections and to have – I mean I don't know. How do you align with a LOINC code for these sections for Problem List with a particular definition of Problem List? I think that's maybe where we're stuck.

Clem McDonald – National Library of Medicine

Well when it comes to the CDA, you can do it because – in fact, Dan you can maybe – don't they request section headers?

Dan Vreeman – Regenstrief Institute

Yes. We include as the – I mean we include as the definition of the LOINC code, the descriptor of the LOINC code, the definition from their guidance. But I think what Jamie is asking is maybe: Is there a more precise way, a more computable way, a more explicit way. I'm not sure.

Clem McDonald – National Library of Medicine

Jamie, were you talking in the context of CDA or a more broad context?

Jamie Ferguson – Kaiser Permanente

Well, I think right now in terms of these different components, we are talking primary in terms of CDA today. But I just don't think that it's – you know when these components of the record are requested, what's returned is not the precisely defined CDA frequently. Right?

Clem McDonald – National Library of Medicine

Well, right. I mean there is a history problem. But I think if you're talking about precisely defined CDA stuff, we can solve – LOINC can solve your problem. If we're talking about who knows what, then we have to settle what the "who knows what" is. And I think for a long, long time that people are gonna request parts of records as attachments. They're going to the paper chart still in many hospitals, and they're gonna pull what they label as whatever they think it is.

Jamie Ferguson – Kaiser Permanente

Well that may be the case, but I think here we're talking about what the EMRs provide. Right? So, this is strictly an Electronic Record discussion here today.

Clem McDonald – National Library of Medicine

Okay.

Floyd Eisenberg – National Quality Forum

And it's strictly to identify that a specific transaction has occurred about a content piece, and I think CDA sections cover that well.

Jamie Ferguson – Kaiser Permanente

Okay. So then – so we're gonna say that the recommendation is LOINC to identify CDA sections?

Clem McDonald – National Library of Medicine

Well, that's the current case anyway. So [pause]...

Floyd Eisenberg – National Quality Forum

Yeah. My – the other question is: The actions of acknowledge versus transmit versus update. How would we – what vocabulary would we use to indicate that? Is that always a LOINC action?

Clem McDonald – National Library of Medicine

I wouldn't think so. Sounds to me like that's deep in the interaction dialogue between systems, which is typically an HL7.

Jamie Ferguson – Kaiser Permanente

Yeah. I would say we have to look at the HL7 Code Tables. I don't know which ones.

Floyd Eisenberg – National Quality Forum

Okay, so we would be directed to the HL7 Code Tables for those?

Clem McDonald – National Library of Medicine

Stan, can you speak to that?

Anne Castro – Blue Cross Blue Shield of South Carolina

Not really?

Floyd Eisenberg – National Quality Forum

Did you say Stan or did you say...?

Clem McDonald – National Library of Medicine

I meant to say Stan. I got a bad voice.

Anne Castro – Blue Cross Blue Shield of South Carolina

Thank God, cause Anne's happy you meant Stan.

Stan Huff – Intermountain Healthcare

Could you repeat the question?

Clem McDonald – National Library of Medicine

Well, the discussion about – you know update – you know the actions taken against the database in messaging or other context; there are some HL7 Tables that describe that sort of thing. You know it's an update, it's a correction, it's a this – and so that the vocabulary they're speaking of is deep in the machinery of HL7. And I was suggesting they would find it there.

Stan Huff – Intermountain Healthcare

Yes, that's exactly right. So, yeah there's the whole list of actually their status/transaction update codes that say whether this is a new thing or an updated thing or a deletion of an error or you know all of those kind of distinctions in [[interrupted] ...

Floyd Eisenberg – National Quality Forum

So let me ask a little follow up to that: If I wanna know there is a Problem List that has been – or a Med List I'll use – that has been transmitted to a patient and that it is acknowledged, would that list be able to identify: A) That transmission occurred and B) That I – would that be able to give me the data I need to know that it was acknowledged?

Stan Huff – Intermountain Healthcare

Let me think. We are getting pretty detailed. But there is acknowledgements at two levels. There is acknowledgement that I received the message. And then there can be, but not mandated, an application of the acknowledgement where basically the receiving system says I got this and I was able to incorporate it as specified in the message.

Floyd Eisenberg – National Quality Forum

So it's more like a fax transmittal that received appropriately – the latter.

Stan Huff – Intermountain Healthcare

Right.

Clem McDonald – National Library of Medicine

I mean the challenge, Floyd, is that all the machinery that you'd want for some of those things doesn't exist in the universe right now.

Floyd Eisenberg – National Quality Forum

I know. I understand that.

Clem McDonald – National Library of Medicine

But a similar vocabulary exists for talking computer to computer.

Floyd Eisenberg – National Quality Forum

Alright. So that's good. So that's the direction to think about. Got it.

Stan Huff – Intermountain Healthcare

So, but I mean – you know there's – yeah it's – you would be able to surmise by watching the flow of messages that the thing had been acknowledged, but there is no – you know there wouldn't be a single code sort of in the message that would allow you to know that in the typical situation.

Clem McDonald – National Library of Medicine

You're looking for like a confirm of C – in electr – in paper mail. You know the signature that the person signed for it and got it.

Floyd Eisenberg – National Quality Forum

Yeah.

Clem McDonald – National Library of Medicine

That's doable, but I don't think systems now have that.

Floyd Eisenberg – National Quality Forum

No, I understand that. We're trying to understand what is there and what is the gap. But, so this is helpful.

Jamie Ferguson – Kaiser Permanente

Well, I mean so there are certainly acknowledgement messages that are specified in HL7 version 2 and version 3.

Clem McDonald – National Library of Medicine

Right, yeah.

Jamie Ferguson – Kaiser Permanente

And those can be used. They're not always used and not always used consistently.

Floyd Eisenberg – National Quality Forum

I mean that's direction; understanding there's a feasibility issue and reality issue. We're just trying – having understood that this is a potential requirement, we want to understand how to represent it and evaluate it. So this is very helpful.

Betsy Humphreys – National Library of Medicine

Okay. So are we ready to move onto the next one, which is Intervention? And can we discuss it with #18, which is Procedure?

Clem McDonald – National Library of Medicine

Please.

Floyd Eisenberg – National Quality Forum

I would agree. I think that I know Jim Walker suggested that we're talking about the – and that's why in the attachment it does say part of the spectrum of procedures. And I know that, I think Marjorie Rallins had some potential updates of the definition on that.

Marjorie Rallins – American Medical Association

Yeah, I had sent that – I basically used the IHTSDO definition for Procedure and Intervention, and it's essentially any purposeful action. And I think that kind of helps us, you know get our arms around it. And then we use that definition in specifying the PCPI measures; and in doing that, things like the diagnostic tests, therapeutic tests, or treatments fall under that category as well. And of course, Floyd you and I have discussed that those could be subcategories of the Procedure or Intervention.

Clem McDonald – National Library of Medicine

I thought those were carved out in this thing.

Floyd Eisenberg – National Quality Forum

Well, they're carved out because generally they use specific terminologies; and that's what keeps them – that's what helps carve them out. But under the broad concept that IHTSDO uses, they could fit. And that's why we were – when I spoke with Marjorie Rallins, we thought that they could be under the broader category but carved out and specific, as opposed to Intervention and Procedure as we have defined it under here being more of a spectrum.

Marjorie Rallins – American Medical Association

Right. It sort of orients our thinking. We would even consider laboratory tests to be a procedure, or we – again, those are again subcategorized beneath that broader category.

Clem McDonald – National Library of Medicine

Well, that's why I think it may not be helpful for this purpose.

Floyd Eisenberg – National Quality Forum

Well for now, here they are carved out. We could potentially use the IHTSDO definition and append to that that specifically Diagnostic Tests and Lab Tests are carved out as separate categories but use the rest of the definition to indicate the broader spectrum for Intervention Procedure, if that works for folks.

Clem McDonald – National Library of Medicine

Well interventions are – I mean as a clinical person – they are pretty clear. You've got surgeries and you've got things you do to people. You know, there is a person there. You're touching them, you're pushing on them, you're doing something. It gets blurry at the edges as all things do. I mean so surgical procedures are crystal clear. And then you have the radiologists that do things and always take pictures along with them, so they're doing them combined. I almost think – and it gets really messy.

Floyd Eisenberg – National Quality Forum

Well, where it gets messier is the comments we're getting from nurses and consumers and others is there are other interventions such as walking the patient 10 feet that if I wanted to indicate a care plan, that the intervention is to walk with the patient and educate the patient on something. And if another intervention

is the patient should do this for themselves at home and indicate they're doing it, then we're going into even a more fuzzy area. But if patient's are documenting they're doing this thing as we're looking at care plans and whether it's successful or not, that's part of what we need to look at.

Betsy Humphreys – National Library of Medicine

But in fact, it seems to me – me thinking about it – it is a lot easier for me to regard walking the patient seems more interventional and procedural than doing tests on the patient's blood in the lab.

Floyd Eisenberg – National Quality Forum

Oh no. I would agree with that. And that's why we've carved out Lab and Radiology.

Clem McDonald – National Library of Medicine

Well, I think the problem is that we get into these high-level theoretic things without the concreteness of what people are talking about. It leads to endless discussions that aren't always fun. Now, if you're talking about a patient recording something they did, that could also be regarded as an observation that they made. And what are lines crossed? It might be better to just deal with the cases. You know, the nursing interventions be called Nursing Interventions.

Marjorie Rallins – American Medical Association

When you say deal with the cases, what do you mean by that?

Clem McDonald – National Library of Medicine

Deal with the specific issues as they exist, instead of trying to make some giant theory that covers them all.

Floyd Eisenberg – National Quality Forum

Well, so here are some of the cases that we've – and part of the challenge we have is we have – if we look at existing measures, they only go so far in terms of what they will be looking f – what they might be looking for and will be as we look for patient engagement in care. But some of them are: There is communication with the patient concerning – and education concerning appropriate diet. So I could call that an intervention, and I've already had that in a measure. How do we discuss that? So I have to be able to talk about [interruption] that discussion.

Clem McDonald – National Library of Medicine

But maybe Education would be a reasonable category, or Education Intervention, so that people know what we're talking about.

Marjorie Rallins – American Medical Association

Yeah, I would agree with that. And those kinds of things – I think we'd spoke earlier – have come from the Nursing terminologies which are now integrated into the SNOMED terminology, so we might want to consider that.

Eva Powell – National Partnership

This is Eva Powell with the National Partnership, and I apologize. I had to join the call late. So, I apologize if my comments are a little bit off. But just listening to the recent conversation, I think that's a really great idea, in the sense that so much of coordination involves these kinds of things. And if we're gonna get to coordination of care and the ability to measure that, then we do need to know some relatively specific but as you say somewhat high-level categories of actions that can then be coded. And I think it takes talking to the professionals who actually do that work to be able to come up with these categories. And Nursing is certainly a major one, but the Ancillary Services, thinking from the hospital prospective, OT/PT, Speech, Social Work, all of those are – they all would have very important elements of a Care Plan that perhaps a working group of Ancillary Services could come up relatively quickly with a list of those.

Floyd Eisenberg – National Quality Forum

And Eva, I appreciate that and I think that would be very helpful. So, just to throw another couple examples here: A patient's use of a peak flow meter for asthma and that they're documenting they're using it.

Clem McDonald – National Library of Medicine

But that's gonna be an observation for sure. Here we get into this duality.

Floyd Eisenberg – National Quality Forum

Well, there are two questions here: One is that they are using it, and the other they're recording results of it. And one is an observation, and the other is they actually did something.

Clem McDonald – National Library of Medicine

There are both [distortion – cut voice] and you get into act – it's a deep circle to get into with this.

Stan Huff – Intermountain Healthcare

I mean this is where I have to bring up my usual – you know I mean my thoughts are just an extension of what Clem said. I mean you need – to do this right, in a sense, – not right; that's too figurative. But to do this in a way that it's an unambiguous and people know exactly what you intend. And to turn it into something computable, you need to say, "Oh, here's the structure for an Educational Session." In the structure of the Educational Session, you have what was the topic that was discussed. Who was taught? What material was provided in terms of handouts or other kinds of things. And if you're talking about other kinds of things like the spirometry and other things you say – you know this is how you note it. And in fact, you can have an information model that allows you to both note whether something is done and note you know – basically note they're using a spirometer and also note the value so that you don't end up with a thousand questions that say: Was the person using the spirometer? Was the person using – you know did they take a home blood pressure? Did they – well you basically create a new code that says yes or no something was done, instead of having an information structure that says – allows you to basically say a LOINC code and then say as a separate part whether it was done or not done, rather than making a LOINC code that says: Was the blood pressure taken?

Floyd Eisenberg – National Quality Forum

Okay. Let me just clarify – this is Floyd. What you're looking at here is the higher-level concepts or categories we're talking about. We may not have all the attributes identified in the model that you just discussed, but we have some of them. We certainly have – by whom, what it is, what the result is – in order to describe that. So what we are looking for is a component of it. Unfortunately, in order to provide a short list of basic things we needed, you're only seeing one piece of the model. And that's somewhat problematic, and I understand that. So I – we can certainly look into providing more detail to you and get recommendations for how to expand it as needed, and even do that offline from the group.

Clem McDonald – National Library of Medicine

Well, the other question is: Some of these things don't have to be constructed or modeled to cover all possibilities of the future. We have the future to get to. But rather what's in the measures now that we need to deal with, so make sure we cover that. And then let the measures as they evolve drive this, rather than our future bets driving it -- you know where it gets hard. Because this whole thing about -- there's a duality in all this stuff. There's drugs – you know you got dispensing, you got prescribing. There's a lot of levels, but you just use a drug code and different pieces of messages or information models.

Floyd Eisenberg – National Quality Forum

An actually on meds that's exactly what we do. We have separate – we have separate – we ask for the drug code, but we have a separate dispense active.

Clem McDonald – National Library of Medicine

And those things are operationally modeled to deliver drugs.

Floyd Eisenberg – National Quality Forum

They are.

Clem McDonald – National Library of Medicine

So, we have the advantage that we have sort of a world experience of 20 years or so. In some of these other spaces we're kind of predicting what the world wants, and maybe we don't need to predict everything until we get there.

Eva Powell – National Partnership

Well – and this is Eva – I think you're right that there is no way that we can predict everything, but I do think that we need to act on what we know is out there that we may not have yet. Because at least in – I just feel like so many times when we have these discussions about measurement, we chase our tails because the excuse for not doing one thing is because something else doesn't exist. And then the excuse for not making that happen is because the first thing didn't exist. And so, it seems to me like the capacity to actually collect information would be one of the first things we need to accomplish if we're moving toward a measurement system that is collected automatically using electronic information. And then from that, measures can be developed. And obviously, there needs to be a feedback loop so that all of this continuously evolves; and that I think what exists already in the form of the QDM that NQF has put together. But I think that you can get at some of this duality by doing what I suggested earlier as pulling together the folks who really are largely left out of the measurement world right now, who we know are gonna be providing the services and care that we're gonna be measuring in the future. And they can tell very – I mean you could probably knock this out in one or two conference calls to get a good working list if we actually talk to the people who are gonna be doing this.

Dan Vreeman – Regenstrief Institute

I would go back to what Clem said -- this is Dan Vreeman -- and let's constrain this as much as possible. I mean as a Physical Therapist, I know the space of interventions that we would provide is wide. And the reason that there is no terminology for it is because it's very different and people don't agree. So let's focus on specifically what do we need to represent in the measures that exist, and then take your approach of getting the people to deliver those things; again, to sort of sort out some of these nuances. But it's just too big a space to be able to do in one fell swoop. So let's try to constrain this as much as we can.

Clem McDonald – National Library of Medicine

I mean to take an easy position, it would be easy to say: If we're talking about surgical procedures, that should be SNOMED. And we could hunt through and maybe make decisions on a lot of these.

Floyd Eisenberg – National Quality Forum

Well, so let me ask a question. If we were looking at basically a spectrum of procedures, would SNOMED be the appropriate place to find?

Clem McDonald – National Library of Medicine

Well, let's – I think that's why it's advantageous to take a position, because you could also say lab tests are procedures.

Floyd Eisenberg – National Quality Forum

Well, that's what I think we'd have to carve that out, because we've already discussed that as LOINC. Right.

Marjorie Rallins – American Medical Association

Right. So then we could look at something like blood pressure taking. That's another action.

Clem McDonald – National Library of Medicine

It's a measurement.

Marjorie Rallins – American Medical Association

Right. So, what do you use for that?

Clem McDonald – National Library of Medicine

LOINC.

Marjorie Rallins – American Medical Association

And see we currently use the SNOMED observable, but I'm open to that as well.

Clem McDonald – National Library of Medicine

I mean we could take these a piece at a time and I think we'd get agreement.

Floyd Eisenberg – National Quality Forum

Right. So we're actually now adding physical examination as a procedure if you're doing that, and that we had carved out specifically because clearly we have seen observables in SNOMED but they could also LOINC – clinical LOINC.

Clem McDonald – National Library of Medicine

I mean we could say Procedures in some way. We don't need any other categories.

Floyd Eisenberg – National Quality Forum

Well, except that then we have to subdivide it for which terminology for which.

Clem McDonald – National Library of Medicine

I'm not arguing for it. I'm just saying it.

Betsy Humphreys – National Library of Medicine

Well, I think that there is obviously – and Jamie might want to comment on this as well, or Stan or whatever – I mean I think there is in practice today, certainly for some of the clinical measurements and physical exam there's more than one thing being used. Right?

Stan Huff – Intermountain Healthcare

Yeah. I mean, you know the truth is that the clinical data isn't being shared nearly as much for instance as lab data or pharmacy data and medications and orders. I mean people are not routinely transmitting in messages blood pressures and heart rates and temperatures or physical exams, for that matter. There is a lot of talk about it. People have done a lot of designs, but there is very little clinical data of that nature that's actually flowing between systems. And it's because they store it in their own system, and they are not – you know the Health Information Exchange kinds of things just aren't that prevalent yet. And so, yeah – I mean truth be known, that you know that kind of blood pressure, heart rate, femur length, head circumference stuff just isn't flowing. You know, it's 1% or less of the flow that you would have for lab data or pharmacy data, medication data, you know text documents; all of those kinds of things are hugely greater volume in actual use than any of the blood pressure/heart rate things.

Floyd Eisenberg – National Quality Forum

Okay, so let me ask a question on that. And unfortunately, I think this is moving to Physical Exam; and I don't know if you want to move off Procedures. But one of my questions for that is: We know measures already need information and they need to specify head circumference; they need to specify many of these things you just said already. And so if that's the case, then we can either just put it in English and let some implementer figure out how to find it and we are back to curly brackets, or we could use some vocabulary standard to at least state it and that would be mapped to whatever we call it locally.

Stan Huff – Intermountain Healthcare

I probably said it – I didn't mean to say that we shouldn't code these things because –

Floyd Eisenberg – National Quality Forum

No, I realize they're not transmitted that way now. But we just want to know what codes to use or what vocabularies.

Betsy Humphreys – National Library of Medicine

They are [interrupted] ...

Stan Huff – Intermountain Healthcare

People put them in the EMR; and yeah, I would clearly be in favor of using LOINC for those things.

Betsy Humphreys – National Library of Medicine

But I mean – this is Betsy – I think this is an area where what is determined for measurement will – all of these, you know all of the decisions that are made here are gonna influence what people do. But in most cases, we're influencing more people to go in the direction that a lot of people have already gone in. In this particular case, I think what I'm hearing is that although these things have been specified to a certain extent – I mean they're within LOINC and also to a certain extent they're in SNOMED-CT; at least within the US, we don't have the use of either one.

Clem McDonald – National Library of Medicine

Well, now's the time to strike and not have confusion.

Betsy Humphreys – National Library of Medicine

I understand. So, but the question is which one to pick. And I know what will be the vote of at least two people on this call. [laughter]

Unknown Speaker (female)

Maybe three.

Clem McDonald – National Library of Medicine

Well for the – in the case of vital signs, History did choose that.

Floyd Eisenberg – National Quality Forum

It did specify a LOINC for vital signs.

Clem McDonald – National Library of Medicine

If that still has any weighting. I think the issue – I mean measurements and procedures – that's why we worry about procedures lumping into together, because there's that duality. You do something and you get a measurement, so anything – HL7 has the "act" and everything's an "act." But, I don't think we wanna give up the common structure for measurements across lab and blood pressures and all the rest, cause they look the same when you're a computer -- or an awful lot alike.

Stan Huff – Intermountain Healthcare

But in the end – I mean aren't what we're really – I mean if what we're trying to do is resolve this line in the spreadsheet that says Procedures and SNOMED codes, I mean I think that's largely correct. As long as we just understand that what – my understanding – the intent of that is that it was – you know we're thinking of either surgical procedures or insertion of an IV or insertion of a Foley catheter or those kind of things, then using SNOMED codes to represent that that action was done is cool. And everybody should understand though that if you get to the edge of that and start talking about the steps that were done to do a hematocrit, that's a procedure but that's not we're talking about in this line item.

Floyd Eisenberg – National Quality Forum

So Stan, I think that fits well. But could I ask: If you included Nursing Interventions, that SNOMED would also be appropriate?

Clem McDonald – National Library of Medicine

If you'd clarify the difference between an action and a measurement, and their measurements – because these procedures are descriptors which can be put in as an answer or into one field. Measurements get more complicated; and when we blend those, we're gonna have chaos.

Stan Huff – Intermountain Healthcare

So I would – you know I think that – yeah it would still – you know what I said would still hold if we're talking about that they turned and coughed the pat – you know that they had the patient turn and cough or they ambulated the patient or they had them do leg raises or whatever. And again, you know the fuzzy boundary is if you go then to “how far did you walk them”, then that's obviously an observation again, or “how many toe raises did they do” or you know –

Clem McDonald – National Library of Medicine

That was a Braden Score – you know where they're talking about the risk of bedsores.

Stan Huff – Intermountain Healthcare

So the fact that it's a score now clearly says it's a measure and that you're talking about the value of the measure as opposed to saying a Braden – you know somebody evaluated the Braden Score.

Floyd Eisenberg – National Quality Forum

I think what I'm hearing – if I can interpret correctly – is that if it's something that is measurable – it is a measure like a Braden Scale, which we actually refer to as a Risk Evaluation, but it's fine however you want to call it – but if we were talking about head circumference or how far someone walked, that would be – am I hearing that is more appropriate in LOINC?

Stan Huff – Intermountain Healthcare

Yeah, those are observable.

Floyd Eisenberg – National Quality Forum

Okay. So observables are LOINC not SNOMED. But what if I wanted to say....[interrupted]

Patrice Holtz – Centers for Medicare & Medicaid Services

Can I...Floyd?

Floyd Eisenberg – National Quality Forum

Yeah?

Patrice Holtz – Centers for Medicare & Medicaid Services

This is Patrice. So can I ask what a Pain Assessment would be classified then as, if you're asking the patient what is their pain on a scale from 1 to 10?

Unknown Speaker (male)

LOINC.

Stan Huff – Intermountain Healthcare

That's LOINC if you're actually recording 7 or 6 or recording the actual score. And if – yeah, I mean in almost all cases, that one would be an observable rather than a – [interrupted]

Clem McDonald – National Library of Medicine

Well, they're also survey instruments or assessments, which we talked about earlier.

Floyd Eisenberg – National Quality Forum

We also use LOINC for those.

Clem McDonald – National Library of Medicine

Yeah.

Floyd Eisenberg – National Quality Forum

So they're both LOINC. But, let me ask a question because to follow Patrice's question: If I wanted to know that a Pain Assessment was done, if I looked for the fact that there is a result – I don't care what it is – it still would use a LOINC code to indicate the Pain Assessment. And if I want to know if the result is

greater than 3 on a 5 scale, or whatever it is, I can ask for it. But if I'm just looking for that it was done and I look for the fact that a result is present, I'm still using a LOINC code because it's the observable that I'm looking for. Is that correct?

Stan Huff – Intermountain Healthcare

That's correct.

Floyd Eisenberg – National Quality Forum

Okay. I just want to make sure this is applied correctly.

Stan Huff – Intermountain Healthcare

Yeah.

Patrice Holtz – Centers for Medicare & Medicaid Services

So all of those assessments that are Nursing Assessments for edema and things like that would all be LOINC?

Stan Huff – Intermountain Healthcare

Yes.

Patrice Holtz – Centers for Medicare & Medicaid Services

Okay.

Marjorie Rallins – American Medical Association

So we're talking about the value of the assessment itself? This is Marjorie Rallins.

Clem McDonald – National Library of Medicine

Well, we're talking about – [interrupted]

Stan Huff – Intermountain Healthcare

Well, you can – yeah again, it's – boy, we need a whiteboard because if – you know, what people are gonna do is actually record the Pain Scale or record any of those things. If it's Incentive Spirometry, they're going to record that they got to 300 mL or they got to whatever the markings are on the spirometer. And if you want to ask the question – you know, what you don't want anybody to do is actually have a nurse chart "did they use a spirometer." You want to chart their observation, and the fact that they charted an observation is evidence that they're using that incentive spirometer. And you don't want to make a new code in either LOINC or SNOMED that says, "Did the patient use an incentive spirometer?" You want to use an information model to indicate an action and have a field that says whether it's "done", "not done", and "what the value of the outcome was." I mean we're getting very detailed in this, but for it to really be understood you've got to talk about sort of the Information Model and the workflow or the expected actions that are happening in the real world that lead you to be able to conclude that an incentive spirometer was used.

Clem McDonald – National Library of Medicine

Just to clarify: When said the value – you know, there's really two things. There is this label or the question, and then there is the answer or the value. And the main LOINC code, the value of it's gonna be a categorical answer; a multiple choice answer, it'll be a SNOMED code. The answer might be a number; of course, then it's just a number. Does that make sense – that distinction?

Floyd Eisenberg – National Quality Forum

Well, I think we did – I think we talked – maybe not in this team but in others – the same with the lab; if it's a numerical, it's numerical. But if there is a concept answer, that was SNOMED as well. Isn't it?

Clem McDonald – National Library of Medicine

In most cases.

Floyd Eisenberg – National Quality Forum

In most cases, right.

Clem McDonald – National Library of Medicine

The ones we've talked about.

Floyd Eisenberg – National Quality Forum

Right. So I think that follows the same pattern.

Rosemary Kennedy – Thomas Jefferson University

This is Rosemary Kennedy. That would be the same for the Functional Status instruments as well, whether the provider is reporting it or whether the patient is putting it into the system.

Clem McDonald – National Library of Medicine

Correct.

Floyd Eisenberg – National Quality Forum

Okay. So it seems – I think I'm hearing some consensus?

Betsy Humphreys – National Library of Medicine

I thought I was too.

Floyd Eisenberg – National Quality Forum

Okay.

Betsy Humphreys – National Library of Medicine

I think that it is helpful to think about the distinction between procedure as a description of the act and a measurement where you have to have, in essence substructure in order to know what's going on with the measurement.

Floyd Eisenberg – National Quality Forum

Right. And I think as we've seen process measures in the past, they've been just looking for is a procedure done. But as we look toward measures of the future, it's not done unless there's a result. And whether that result is important to the measure or not, we still would look for it as a resulted test or a resulted piece of the process. And I think that that would fit well into what I just heard today.

Stan Huff – Intermountain Healthcare

I think so.

Floyd Eisenberg – National Quality Forum

I mean there are still occasions when we need to know it was ordered and that's enough. But if we need to know it's performed, it doesn't matter if you care about the result or not, you still use the same vocabulary to indicate what was done.

Stan Huff – Intermountain Healthcare

Yeah.

Clem McDonald – National Library of Medicine

Recognizing that as you get more experience, there might be some tweaks and modifications.

Floyd Eisenberg – National Quality Forum

I think that what we're gonna find is as people start using this to create measures, there will be additional questions that come that we'll have to start – I mean a methodology to resolve, but I think this goes a lot further than where we have been so far.

Marjorie Rallins – American Medical Association

Yeah Floyd – this is Marjorie – and I think that’s a good distinction, using this to create measures. Because the challenge that I see is applying this work to measures that already exist. If someone wanted to sort of make their current measure fit with an electronic health record, the measure language doesn’t currently – doesn’t always allow you to sort of tease out sort of the distinctions between the test being performed and the test being resultated, etc.

Floyd Eisenberg – National Quality Forum

Right.

Marjorie Rallins – American Medical Association

Yeah.

Floyd Eisenberg – National Quality Forum

And part of that space on the fact that there has been an expert committee that looks at it that’s longer in place to go back and review and say is that what we meant. And that becomes difficult with the retooling. But as we go to the future, I think it will make it simpler. [indiscernible – multiple voices]

Marjorie Rallins – American Medical Association

Correct.

Aneel Advani – Indian Health Service

This is Aneel Advani from IHS. I have one comment on that thought. I mean I think the other heuristic – other than the one to say that we will be getting additional results as well as the claim or the intervention because we have the EHR information flow, is to look forward to Stage 3 and really drive home the point that was made earlier just now that Quality Measures and Workflow and Guidelines, as was mentioned before, are sort of all elements of the same idea of formulizing care and providing reasoning formulization. And so, as we get to Stage 3, I think we should pick vocabularies that have the potential to also support formulized Decision Support and formulized Guidelines, with Quality Measures and Decision Reminders sort of flowing from that. And so I think that’s the other sort of heuristic rule here.

Floyd Eisenberg – National Quality Forum

This is Floyd. Aneel, I really appreciate that. And probably before all this started, that would have been a good rule to keep in mind. But, I’m hoping that what I’m hearing and I think what I’m hearing follows that rule. But I would agree.

Betsy Humphreys – National Library of Medicine

Okay. I have a feeling we’ve already – have we already talked about Adverse Effects?

Floyd Eisenberg – National Quality Forum

When we talked about Allergy, we merged that together. Yes.

Betsy Humphreys – National Library of Medicine

Okay, fine. Does anyone have – I mean Lab tests were LOINC for the test, were UCUM for the units, and SNOMED-CT in those cases where the result or the answer is reasonably represented in SNOMED. So does anyone have any objection to this or any disagreement with it?

Clem McDonald – National Library of Medicine

Well, there’s two things in the text statement. It says SNOMED for test ordering/result. What is that supposed to mean?

Betsy Humphreys – National Library of Medicine

Oh, okay. So then, we’re here at the day of “Orders.” Right?

Floyd Eisenberg – National Quality Forum

Right. So the first was: If I want to know what is the ordered test as opposed to the resulted test. Do I use the same thing?

Betsy Humphreys – National Library of Medicine

So I think that there is no disagreement about the results from what is here: LOINC, UCUM, and SNOMED-CT. I don't think there's too much argument. The issue on Lab test orders I think is more complex.

Clem McDonald – National Library of Medicine

It's gonna be a mess if you have the same thing which is often ordered as – it's the same thing as the test result. And I believe the HITSP group decided LOINC and Orders. We put out the top 300 Order List for that purpose. So I thought there was LOINC for Orders and for Results.

Betsy Humphreys – National Library of Medicine

What about the issue of "Panels?" Isn't that how people are actually ordering things?

Clem McDonald – National Library of Medicine

LOINC has panels. It's just that: Can you cover all the infinity of panels? And it hasn't.

Jamie Ferguson – Kaiser Permanente

Right. That's the so-called "Order Compendium" issue, which is that basically each lab issues their own panels and profiles which are combinations of panels and individual tests that can be ordered. And then, in many cases, they customize them for particular customers. So there really isn't a standard for that today.

Betsy Humphreys – National Library of Medicine

Okay, so is there a question about whether LOINC is the answer for Lab test orders or not?

Clem McDonald – National Library of Medicine

It's the closet you got.

Floyd Eisenberg – National Quality Forum

So, I realize it probably isn't – I don't know that's it's done this way in practice, but wouldn't one think, expect, or could I expect that whatever panel is chosen, if all of the tests within it each of them had a LOINC, they're basically creating their own value set that covers what's in that panel? So if you just break out the test within it, you would be able to find what you're looking for?

Jamie Ferguson – Kaiser Permanente

Yes. And you know one of the things that was a notable difference between the HITSP Lab Spec and the E-LINKs Result spec is that basically the HITSP spec required unique order codes for each individual test within the panel basically. So I think that is a long-term direction, but it's not where we are today.

Clem McDonald – National Library of Medicine

Well, there is a new order – E-LINKs has a new order message structure and they include LOINC in it.

Jamie Ferguson – Kaiser Permanente

Right. But I'm saying that the issue of the individual test orders, as we move up from 251 through 2.6 to 2.7, that becomes mandatory. So –

Floyd Eisenberg – National Quality Forum

So I think the answer then is that it's still LOINC for the order as well as the result of the test.

Jamie Ferguson – Kaiser Permanente

I think that's right – about the reality today.

Clem McDonald – National Library of Medicine

I mean the truth is in all this coding world, there's gonna be exceptions for a long time because the world moves really fast.

Betsy Humphreys – National Library of Medicine

Okay. I think we have, once again, taken too long to discuss these items. It's probably my fault. But in fact, this call is scheduled to end in about 5 minutes; and we do have to allow time for public comment.

Stan Huff – Intermountain Healthcare

Then we better do it.

Betsy Humphreys – National Library of Medicine

Yeah.

Judy Sparrow – Office of the National Coordinator

So you wanna do that now Betsy?

Betsy Humphreys – National Library of Medicine

I think so. Jamie, what do you say?

Jamie Ferguson – Kaiser Permanente

Yeah. I think that's right. And Betsy, thank you for leading this call.

Judy Sparrow – Office of the National Coordinator

Yes, thank you. And Operator, can you check and see if anybody does wish to make public comment?

Operator

Yes. If you're on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. [Pause] And we do have a public comment.

Judy Sparrow – Office of the National Coordinator

Right. Thank you. Can you please identify yourself?

Carol Bickford – American Nurses Association

Carol Bickford, American Nurses Association.

Judy Sparrow – Office of the National Coordinator

Go ahead.

Carol Bickford – American Nurses Association

I would like to comment on the last discussion in relation to the Laboratory tests and the concern about SNOMED-CT. Taking a look at the Supporting Discussion addresses the use of SNOMED-CT to append the clinical reason. It would seem that that would be something that would need to be carried along, and not just relying on LOINC for the naming and the UCUM for the measures. That similar concept would be absolutely critical for Radiology tests. Is Radiology testing going to be considered in discussion, or is that not part of the conversation?

Clem McDonald – National Library of Medicine

I think it's gonna be part of the conversation, if I could – no one else is talking. But regarding the reasons, that's always been thought of as a separate dimension which would be SNOMED. So I don't – it's part of the order structure – it's part of the test structure, but it's not – we just weren't focusing on it in the discussion.

Judy Sparrow – Office of the National Coordinator

Okay, thank you. Do we have any other public comment?

Operator

We have no more comment at this time.

Judy Sparrow – Office of the National Coordinator

Okay, Betsy back to you.

Betsy Humphreys – National Library of Medicine

Alright. I think that we're going to have to get back here about finishing this job. [laughter] And when we can – you know, what we have to do to get through the rest of this thing.

Judy Sparrow – Office of the National Coordinator

Right. Okay, well I'll work with the Chairs to see if we can find an agreeable date and time.

Clem McDonald – National Library of Medicine

Is someone summarizing the discussion so that we'll have an updated table?

Judy Sparrow – Office of the National Coordinator

Yeah. I think somebody from Tom's shop is going to be doing that. Okay?

Betsy Humphreys – National Library of Medicine

Alright.

Judy Sparrow – Office of the National Coordinator

Alright. Well, thank you everybody.

Betsy Humphreys – National Library of Medicine

Thank you.