

**Vocabulary Task Force  
Draft Transcript  
July 11, 2011**

**Presentation**

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good afternoon or good morning depending on where you are. This is the Vocabulary Task Force call and as an advisory call this will be public and there will be an opportunity at the end of the call for the public to make comment.

We're going to do a quick roll call – Jamie Ferguson?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Betsy Humphreys?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Clem McDonald?

**Clem McDonald, Director, National Library of Medicine**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Stuart Nelson? Marjorie Rallins?

**Marjorie Rallins, American Medical Association**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

John Halamka? Stan Huff? Chris Chute? Marc Overhage? Daniel Vreeman?

**Daniel Vreeman, Regenstrief Institute**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Floyd Eisenberg?

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Karen Trudel? Donald Bechtel? Patricia Greim? James Walker?

**James Walker, Chief Health Information Officer, Geisinger**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Greg Downing? Chris Brancato? Andrew Wiesenthal?

**Andrew Wiesenthal, IHTSDO (SNOMED)**

Yes

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Bob Dolin? Amy Gruber?

**Amy Gruber, CMS**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Ram Sriram? Ken Gebhart?

**Ken Gebhart**

Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Lynne Gilbertson?

**Lynne Gilbertson**

Here

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Nancy Orvis? Anthony Oliver? Marjorie Greenberg?

**Marjorie Greenberg, HHS/CDC**

Here

**Judy Sparrow – Office of the National Coordinator – Executive Director**

And from ONC, Doug Fridsma? Anand Basu? Do we have anyone else on the call?

**Clem McDonald, Director, National Library of Medicine**

Is Stan Huff on the distribution list?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

He's not on the latest version that I have but – oh excuse me, he is here.

So I will turn it over to Jamie Ferguson.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Thanks very much. This call is a continuation of our previous 2 calls going through the working document for stage 2 recommended quality measures and the vocabulary data requirements for them. There were actually a few items, a few questions that were referred back, so Floyd Eisenberg, I wonder if you can take us through those items that were up for current discussion.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Sure. There is a spreadsheet that was sent out to the task force. I believe we left off on medications?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Yes, the issue was there were several topics that were referred for additional action by the Vocabulary Task Force after the joint working group call.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Oh, that was for evaluating measures around disparities so as a request from some of the groups in HHS to include within all measures. I'm sorry; I think that's what you're referring to.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I'm actually referring to the fact that the first call we had on this topic Jim was chairing. We ended up with referred to the Vocabulary Task Force with additional discussion. The issues around patient characteristics because we thought that there were apples, oranges, and monkey wrenches under that one rubric and it was very difficult to say one thing for all of them. We wanted to have more discussion about exactly which ones were the first ones we had to worry about so that we could accurately assess. Then there was one aspect of conditions diagnosis and problems we were going to follow up on. There were non-laboratory diagnostic studies and then there were questions around all communications and encounter ones in terms of what we were talking about here related to vocabulary standards versus what we were talking about in terms of other aspects of patient record in which you would document the communication that has taken place between the patient and the provider.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think for this call we wanted to go back to items that were referred back and tackle those before we get back into the spreadsheet line by line.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

So, what was referred back in terms of characteristics to be specific, one of the issues that are being lifted were about race, ethnicity, preferred language, payor or insurer, and there was a question about socioeconomic status if that's to be include as well.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

And so, I have a question for all of us and Jamie you've read this and I didn't but there is a current request for information or comments out, maybe that's what it is, getting people to propose things under the Affordable Care Act which has a deadline of 1 August. It covers several of these items: race, ethnicity, primary language, sex, and disability status.

**Marjorie Greenberg, HHS/CDC**

Right, that comes out of the Congressional requirement out of the ACA also.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, and this is coming out of the Office of Minority Health and so rather than referring to accredited standards for those things, for example, on proposed data standard for ethnicity it has listed checkmarks for A through E, Hispanic, Latino, or Spanish origin is one, Mexican or Chicano is another one, Puerto Rico is another one, Cuban is another one, and another Hispanic Latino or Hispanic origin. That's it for ethnicity. Race is approximately a dozen or I guess thirteen checkmark categories. It looks like they align with the census categories.

**Clem McDonald, Director, National Library of Medicine**

The census categories for ethnicity have a hierarchy and I'm not sure it covers all those categories of Hispanic but it might.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

So, that's it for ethnicity and then race is a checklist of A through N. And then primary language is English, Spanish, or other. Just to focus in on the primary language for a minute, some of us were having a little discussion on this off-line. HL7 recommends the use of ISO 639 –

**Marjorie Greenberg, HHS/CDC**

Yes, I recommended that to this group but it was rejected.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, but in fact there are about a half a dozen different standards within ISO 639. There is one that's used for which the registration authority is the Library of Congress and I think you had referred to that one and Marjorie this may be what you were referring to as well. It's a three alpha code that included approximately 500 languages but approximately half of them are dead languages and there are probably 100 category codes in there such as families of languages with a three character code. Whereas there is another part of ISO 639 standard that's 639-1 that's a two character alpha code that is approximately 200 languages that are currently spoken in the world. So, if we were going to recommend one of the ISO 639 standards, I would recommend that we focus on the current languages rather than the one that's used by the library that included both the categories and the dead languages.

**Marjorie Greenberg, HHS/CDC**

The National Uniform Billing Committee which maintains the code set for the standard and the content for the Uniform Bill for hospitals did adopt this because several states did adopt this ISO standard – I'm trying to find a particular version of it – but I don't remember that the Library of Congress –

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I think that what Jamie was referring to is the other one in essence is a smaller subset, Right, Jamie?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, there are a half a dozen standards within ISO 639. It's 639-1 through 639-6. And so the 639-2 is the one that is used by libraries and that's maintained by the Library of Congress. The 639-1 is the two character code that serves all the current spoken languages. Others have to do with comprehensive coverage of languages, codes for language families and groups and representation of language variance.

**Marjorie Greenberg, HHS/CDC**

I think what the NUBC adopted was 639-2.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, now the issue with 639-2 for spoken preferred language in a medical setting is that it includes as I said, about half of the codes are category codes and dead languages.

**Marjorie Greenberg, HHS/CDC**

Well of course you don't have to choose any of those but I know that California for example adopted 639-2 but then they have a much smaller list from that.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

And so 639-1 is a proper subset of 639-2.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

But uses two characters instead of three character codes?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Uses two characters instead of three characters, right.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Suppose that people might have preferred the three character codes as being potentially more self-evident.

**Marjorie Greenberg, HHS/CDC**

I think they did, that's why they took the two.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Ok, so I will say that in most cases or for a lot of the standards the more standard languages that we would have more people speaking, you're dealing with for example, RUS for Russian as opposed to ROM for Romanian. Do you see what I mean? It is easier to distinguish certain things.

**Marjorie Greenberg, HHS/CDC**

Right.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

They are just codes. There is usually a full text that goes along with it.

**Marjorie Greenberg, HHS/CDC**

By the way, I should point out that what is out now for public comment is really what's recommended for surveys and I think the decision was made in that environment by the workgroup and I was not a member of the workgroup though I have heard their reports at data council etc. For surveys the only likely options are either English, Spanish and maybe other. That of course would not apply for clinical records and electronic health records. Although I think the requirement under the ACA is broader, I believe that what has been put out for comment is really only for surveys.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

You're probably right. I think that what we need to do is be sure that we can clearly explain what we're doing and why it isn't the same as what they are proposing.

**Marjorie Greenberg, HHS/CDC**

Exactly.

**James Walker, Chief Health Information Officer, Geisinger**

Would it be reasonable to propose then that we use the three alpha two code and recommend that expeditiously either identify or develop a subset of that that represents the experience of urban and other cosmopolitan areas in terms of what is the set of languages which actually need to be able to have translators in order to communicate with your patients.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Jim, can I add something to that from Jamie's comment? Would that mean a map from the 639-2 to 639-1 and that would represent the subset of 639-2 that we would use?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, and the problem with doing that Floyd is that it's not a one to one. So, for example for Romanian, there's one code which is RO in 639-1. There are 4 different three character codes.

**James Walker, Chief Health Information Officer, Geisinger**

I would guess that we would be better off starting from the three character code but just identifying a clinically relevant subset.

**Clem McDonald, Director, National Library of Medicine**

Can I jump in on Jamie's behalf? Looking at Wikipedia there's 184 codes in 639-1. The current version is 2002. The current version of 639-2 is 1998 and there is more than 450 terms in them. If someone has a subset that works pretty well, the size of the code shouldn't be determining – what if the numeric codes didn't have any meaning? I don't think we should be picking code systems based on the nomadic.

**James Walker, Chief Health Information Officer, Geisinger**

I was thinking more in terms of the specificity – at least for Chinese for instance, the sub-language matters whether it's Mandarin or Cantonese. So if the two alpha codes had that specificity then that would be fine.

**Clem McDonald, Director, National Library of Medicine**

Do you have it in front of you Jamie? I'm guessing it would because it's current languages.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Is there a reason why we should pick something different from what they picked for the Uniform Bill if it covers everything?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

That's a great point.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

If they have picked –

**Marjorie Greenberg, HHS/CDC**

They spent a year on this, I must say.

**Clem McDonald, Director, National Library of Medicine**

But I thought I heard you say they picked just three codes.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

They picked the three character version which is –

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

They picked the three character version but it seems to me that if people have to use the three character version for the Uniform Bill and it covers everything we need, why would we pick a different one?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

We can make a recommendation that there should be a subset and perhaps the subset that you start with is to look at the subset of the -1 code.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

And I gather from what Marjorie Greenberg was saying earlier that the Uniform Bill folks may have already produced a subset.

**Marjorie Greenberg, HHS/CDC**

I don't think it was produced at the National level. States that have already implemented this have produced a subset. So California which probably is as diverse a population as you can almost think of but maybe not some of the groups that are also in Minnesota, they have for their purposes come up with a subset and other states that have implemented this have also come up with subsets. I don't think there is one National subset and I'm not sure that there should – well, I mean there sort of embedded with each other so you would want California to use the same thing for Romanian as Minnesota would but Minnesota might not even have it in their subset because there is so few of them.

**James Walker, Chief Health Information Officer, Geisinger**

I think the purpose of a National subset could be for organizations that don't have the internal capital to do it themselves. It could say, this is all of the languages that some clinical organizations have found an actual need for.

**Marjorie Greenberg, HHS/CDC**

And that's sort of the ISO.

**James Walker, Chief Health Information Officer, Geisinger**

No, that's not the ISO at all. My guess is if you did this number this subset like this it might be 50 or 60 or something.

**Marjorie Greenberg, HHS/CDC**

I agree with you. What I'm saying is it's sort of like when we were talking before, the system doesn't break because you have the background of the 639's and if somebody shows up with something that nobody has seen before, you have a way to code it.

**James Walker, Chief Health Information Officer, Geisinger**

Right.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Just think, by going with the three character one we have the differential between the official Aramaic and imperial Aramaic. Have you seen how the Chinese is separated in that one?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I know it would be separated in this one thing. I think there is the advantage – it almost seems like we're looking for trouble or we're trying to cause it if we don't pick the same one that's used in the Bill.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, that's right. But I think a place to start looking at subset may be with the two character codes which are really the spoken languages.

**Unidentified Man**

The only thing I caution is I think the use case here is for CMS where the request is going to be able to do some kind of multi-varied analysis to look for differences and if we do have differences by state perhaps there's actually a harmonization effort that needs to occur so that they can meet their use case. In the near term I can understand going the direction Jamie just mentioned.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Well, the question I guess is, are you recording the information?

**Unidentified Man**

The first question, yes.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

At what level of specificity? If we're using this data we're talking about it seems to me it covers everything and then the issue is what are you collecting?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Well it covers everything, but my concern would be which of the four codes for French are you using and is everyone using the same code for French?

**Andrew Wiesenthal, IHTSDO (SNOMED)**

This reminds me of a debate that we had when we were substantiating our system. It's not about language codes but it's about race and ethnicity. If you think about this operationally, who's going to ask the question and who's going to answer. So we had the debate and used the entire... of US Census codes for race and ethnicity in a live critical setting or do we use a much smaller aggregated subset. It came down to the fact that there are apparently six different kinds of Ashkenazi Jew and I didn't know which one I was. Somebody who didn't know anything at all was going to be asking me, an ignorant person who should know, and the data was going to be garbage. If somebody has already decided what to do, as defective as we think that might be, we should just do that.

**James Walker, Chief Health Information Officer, Geisinger**

It sounds to me like we have consensus that we use the three alpha two code because that's what is being used and then that there is a need to develop a subset of that, as Andy says, useable by the people we expect to put the information in and also represent the range of patient needs and CMS' need to make – CMS probably doesn't need to know the subdivisions of the four kinds or six kinds of Ashkenazi Jews

but they probably do need to know Cantonese and Mandarin. Maybe they don't need to know that either but I think we can take that off the table and say we're going to start with the three alpha two code and then work on a useable subset.

**Clem McDonald, Director, National Library of Medicine**

It turns out there is a very nice report that includes both of them in one table. Alpha and Tibet to – I don't have this email right off the bat – then we can distribute it. You can get from one to the other fairly easily. There is also an English and French name for each of them and I think we probably ought to push for, well I don't want to push too hard, but if they use the usual HO72 approach you'd have a name and a code. So it would be easier than ever to read.

**Marjorie Greenberg, HHS/CDC**

Are you sure that two includes extinct codes? I thought that was three.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, two definitely includes extinct codes as well as higher level classifications and groupings of languages.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

You understand, obviously, it's the one being used for records for things that were written in classical Greek thousands of years ago. It has to have all the dead languages as well as the live ones.

**Marjorie Greenberg, HHS/CDC**

So we're not just talking spoken language here.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

No, it covers all and so therefore a subset is suitable for our purpose.

**Marjorie Greenberg, HHS/CDC**

Well I have confirmed here that definitely 639-2 that was adopted by the NUBC.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

That's a good reason as Andy, Jim, and others have said to go with that. I think we have consensus on that and it took us less than a year.

**Marjorie Greenberg, HHS/CDC**

Sometimes we don't have to reinvent the wheel.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

What about the race and ethnicity codes?

**Unidentified Man**

Well I thought everyone had been leaning toward the existing Census ones, but if they are going to be re-reviewed we'll have to take that into account.

**Betsey Humphreys, Co-Chair, National Library of Medicine**

The recommendation of the Quality Measures group was in fact that we use HL7 –

**Unidentified Man**

Oh, ok.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

for administrative race, gender and ethnicity. I haven't looked at that myself, so whether that's a great idea or not –

**Unidentified Man**

I know that the race was based on an ISO race and I think the other ones were based on some thoughtful consideration but they are simple and intended for administrative use.

**Marjorie Greenberg, HHS/CDC**

I know that HL7 and X12 have adopted as an external code set the OMB standard. As I recall what was basically in X12 and HL7, they were duplicative and you might have Black and African American overlapping and that's why CDC put forward the OMB standard which is the basic 5 categories. Then they are very detailed which is essentially used in the census. But it's an external code set maintained by CDC. What I don't know is when quality recommended HL7 whether they recommended this external code set or not because I think the external code set is the one that's consistent with the OMB requirements.

**Lynne Gilbertson, NCPDP**

The HITSP recommendations pointed to the PHINVADS system which is the CDC for race and ethnicity and that's what NCPDP has incorporated in their standards as well. I think they are the HL7 that you talked about but I'm not quite sure how the bridges gap.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Well it seems to me that referring to this CDC thing by what it is officially called would be a better approach rather than referring to HL7.

**Marjorie Greenberg, HHS/CDC**

I think there may be an HL7 version that is not the same as the external code set.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

If we have something that is referred to already by X12, NCPDP, and HL7 at some level, that sounds like the one to pick unless it doesn't meet the use case.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I'm looking at it now on the CDC site. They have a 966 code system concepts within the race and ethnicity; it looks very comprehensive.

**Unidentified Man**

I would worry looking at it too. You've got Bel Air at Icelander and Canarian –

**Marjorie Greenberg, HHS/CDC**

You could collapse – it's hierarchical.

**Unidentified Man**

Well it may be but when you're trying to check someone in, whatever is required on the menu they are going to check in off of and what are they going to be able to get out of the patients. So, if this becomes imposed on all communications as a minimum, it could be very disruptive.

**James Walker, Chief Health Information Officer, Geisinger**

Aren't we in the same place as the last discussion? We really do need to identify the language from which then a limiting code set would actually be useable is derived.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

There are, as Marjorie said, there are hierarchical codes within that and in essence if you specify the first four characters then you get at the next hierarchy level up.

**Unidentified Man**

We need to get clear though, what are we specifying in the standard? Are we specifying that one must accommodate these, one must collect these?

**James Walker, Chief Health Information Officer, Geisinger**

I agree and I think we need to be at least ready for the likelihood that a useable list may have different levels of hierarchy. Just to go back to one I almost understand, for Chinese it may be Mandarin or Cantonese not Chinese whereas for Romanian it's just Romanian, not four kinds. So a useable list will enable clinical people to actually document this in a way that CDC and others get something they can use will be to have a list that can't be very much more than a couple score and that really represents clinically relevant distinctions whatever the level of hierarchy those happen to reside at.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

If there is a hierarchy and it's evaluated by the number of digits, is it possible to specify up to the 2<sup>nd</sup> or 3<sup>rd</sup> digit or character but not deeper?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

It would be I think the first four characters. Let me give you an example – E104 says South American, this is for race and ethnicity, and then there's a .001 through .011, for Argentinean, Bolivian, Chilean, Columbian, Ecuadorian, Paraguayan, etc. If you said E104 that would be South American; that would be the first four characters. You can either go the first two, or the first four, or the whole thing.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

So the thing we're saying here is, once we say that from my perspective, we have possibly said nothing about race and ethnicity right? Saying that I'm an Argentinean if I were one –

**Marjorie Greenberg, HHS/CDC**

Which is really ethnicity, I think, it's not really race.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Yes, ok.

**Unidentified Man**

I think Betsey is right – well it depends on your definition of ethnicity.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

These are the ethnicity concepts.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Ok.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

But it's similar for the race concepts. For example, our 402 is Micronesian and then you have 13 different Pacific Islander types within that.

**Marjorie Greenberg, HHS/CDC**

Pacific Islander is a race according to OMB.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

That's just the first two characters –

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I guess once again, if there have been wars about this already and certain candidates have been left on the field and are now specifying for use in X12 and HL7 and NCPDP, do we really want to re-do this?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

No, I think what we're saying that the CDC, PHINVADS, race and ethnicity codes are the ones to use and we're now talking about how to subset them.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Ok.

**Unidentified Man**

For this discussion, couldn't we put that on the parking lot?

**Unidentified Man**

One of the challenges we have is once these kinks turn into regulations, the interpretation then has an ICD coding you must code to the most specific. So you get this additional cinch around your behavior. I'm looking at it too and it goes down to five different brands of Patawami Indian tribes.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, so I think for example, the census codes are just the first two characters.

**Unidentified Man**

Maybe we should say that? Let someone that wants to use it can get to the other ones rather than start with everything.

**Marjorie Greenberg, HHS/CDC**

There was a report that came out of the Institute of Medicine that actually didn't completely agree with the CDC code set and because it wanted in a sense more granularities and I agree with what I'm hearing, we have to balance some of these recommendations that are really related to capturing disparities, etc. against what is realistic to capture if you're going to put it in regulation. We know for a minimum that the OMB standard – I don't think we can contradict that. But when you get into these greater levels of granularity, I think you should have the ability to capture them in a standardized way but what should be required – I'm not sure beyond the OMB basic standard.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think if we recommend a subset and just acknowledge for research and other purposes it could be extended.

**James Walker, Chief Health Information Officer, Geisinger**

Do we have the ability at this point in the analysis and at this point of the recommendations to Standards and Policy Committee, to say the codes that should come out of this language and maybe this level of specificity, 2 digits for the CDC say, and use of every one of these categories should not be required. But what could be recommended or required would be a code set to be developed and approved separately.

**Clem McDonald, Director, National Library of Medicine**

I like your first thing without the second one –

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Well, yes there is also a different approach that we could consider which would be a differentiation between the EHR certification program vs. the meaningful use incentives and other usage. For example, if EHR software had the capability of containing all the characters of the hierarchical codes but if the use of those in terms of eligible professional and hospital usage were constrained to the first two characters, that would mean that the system would have the capability of getting more granular data that may be useful for research purposes but the measurement of providers would be just on what's practical for most people to implement.

**James Walker, Chief Health Information Officer, Geisinger**

Following that I think that if some organization wanted to get more specific and have patients enter their own data, the extent the patients know their own data, they could do that and it wouldn't limit them.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

That sounds reasonable to me.

**Marjorie Greenberg, HHS/CDC**

Yes, to me too.

**Unidentified Man**

This is barring further specification from our Medicare colleagues that have asked for this is how deep did they want this to go but I think this sounds reasonable.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Of course at the same time I don't know if we have any EHR vendors on this call who could speak perhaps from their position on that.

**Andrew Wiesenthal, IHTSDO (SNOMED)**

I won't answer for them or won't pretend to speak for them but first of all they have a field, they all have fields for race and ethnicity, and asking them to accommodate one fully specified and then with the potential for sub setting that is probably something they've already thought of.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Most databases are not very tight on the number of bites you can put in anyway but I could just picture where there is already a line for people checking in. The line is going on for months if you had to work through this kind of a list. Nobody is going to know the answer nor will the clerks be able to interpret if they are getting the right answer, so I think if we stay with the first two digits is what is required and not get into the rest of it except that intelligent people can find them and use them as they wish.

**Marjorie Greenberg, HHS/CDC**

I think the only reasonable way to deal with such a granular list is, as someone suggested, if there is self-reporting and behind that is some electronic version that just matches it up with what's self-reported. But this is not something that could be inquired by a clerical person. This would be absurd as you suggested. More and more we're moving towards things like patient reported data and behind it you have a fairly simple look-up table electronically, then it just happens. I don't think that should be required for meaningful use but I see that as a way to go.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I don't disagree with that but at the same time, I'm thinking of, for example, regional and local differences where there may be a hospital that serves an Asian community that wants to be able to differentiate in their EMR between Chinese, Philippine, Japanese, and Korean patients rather than sticking to the 2 character census code of Asian. So I think having the ability through the certification program to have the full specificity not requiring that for meaningful use, but allowing it where local implementers want to use it, seems like it might be a good compromise.

**Clem McDonald, Director, National Library of Medicine**

The census bureau does have a step down from this doesn't it? I know the Surgeon General form does. It goes one step down. But I'm looking at the 12 Apache categories, this is partly political and you can imagine people in Germany saying we want separate codes for ourselves because there are more of us than there are from Ft. Apache. It could go on forever.

**James Walker, Chief Health Information Officer, Geisinger**

It seems to me that we need different levels of requirement. If we said at the top level, and I think we need to deliver soon, we said anyone that codes, race, ethnicity, gender, whatever, uses this language. This would be a huge step forward. And then if we said for EHR certification or HIT certification, any tool has to be able to manage the whole terminology to full specificity. Then for meaningful use, there's another requirement that says this is the clinically relevant sub set of whatever this is, that we're going to agree at a National level will collect and report and try to act on. If we regard those as three completely separate

things, and I think regard our work here, which needs to be done in a month or two, as saying just the top level, whoever does this is going to use this language. Not that anybody is required to use the whole language, certainly not that every clerk is required to be able to look through 450 of anything, but just whatever you do, it will come out of this language and then specify the next – well, ER certification is probably pretty easy, we just say if you bill HIT and want certified you'll have to be able to deal with the whole code set. At the next level, say we'll create a clinically relevant set that if you'll use it, you'll meet reporting requirements whether it's reporting to CDC, meaningful use, FDA or whatever.

**Clem McDonald, Director, National Library of Medicine**

I wouldn't go to those next two steps because of the burden on the practices.

**James Walker, Chief Health Information Officer, Geisinger**

That's alright. I would be very comfortable saying for right now we're just going to do top level and then have the other discussion if we want to later. It wouldn't be a requirement it would just be a clarification. The only requirement would be, if you do this activity at whatever level for whatever purpose, use this terminology to do it with.

**Clem McDonald, Director, National Library of Medicine**

I agree with that.

**James Walker, Chief Health Information Officer, Geisinger**

By the way, that would make the scope of our discussion semi-manageable.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

With that understanding, do we have consensus on Jim's proposal?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I think its fine.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Ok, good. Floyd and Betsy what's next on the list of preferred items?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I guess we have taken care of all of the characteristics. Did we not decide that if you were in fact soliciting information from a patient, like do you smoke and how many packs a day or whatever, then that comes under observations and we've covered them elsewhere?

**Floyd Eisenberg, National Quality Forum**

I think that's fine. There was one additional and that was how do we deal with payer? Which is also a request from Medicare to include.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I did not know what they meant by that. I didn't know if they wanted to know who the payer was or whether they have some category of payers that means something to them that they could tell us what it was.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

It was sort of vague. Their categorization is type of Medicare or Medicaid program and they do have I believe it's Medicare Advantage vs. a,b,c,d,e for service and them Medicaid. But I think they were looking also for other insurers and they were looking for some classification if there is one.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

There are classifications in billing systems like Medicare, self-pay, Medicaid, I think there's at least 9-10 of them. That's part of the UBO2? I don't know if that's what we're talking about.

**Marjorie Greenberg, HHS/CDC**

There is a payer typology that is also an external code set to X12. I'm not sure if it is to HL7 that was developed by the Public Health Data Standards consortium, again it's hierarchical.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

It would seem to me that again, whatever is used or endorsed by the UBC folks would be sensible here. They are the ones that deal with payments.

**Marjorie Greenberg, HHS/CDC**

Part of the question is what is the payer ID going to look like?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Well if there was a payer ID I'm sure everyone would prefer that.

**Marjorie Greenberg, HHS/CDC**

Possibly, but possibly not. We are still waiting I think to see that. But it has been recommended that this payer typology, which as I said is an external code set that was recognized by X12, and it's a real standard, it's not duplicative, it has definitions, all of that, be incorporated into the payer ID but I don't know that it will be. Again it's hierarchical, so if all you know is Medicare or all you know is BlueCross or whatever the categories are, then that's all you know.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I have to say if X12 has a standard or the UBC group has it, why don't we just say that's it?

**James Walker, Chief Health Information Officer, Geisinger**

I agree.

**Marjorie Greenberg, HHS/CDC**

I certainly agree.

**Clem McDonald, Director, National Library of Medicine**

We don't know if that's what they wanted.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Well, that's their – you should not be coming to the Vocabulary Group, which is what I believe we are, to define the typology of payers.

**Clem McDonald, Director, National Library of Medicine**

I agree 100%.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

They should adopt whatever is already in use by the people who are responsible for the administrative standards.

**Jamie Ferguson, Chair, Kaiser Permanente**

Let me go back. Floyd, can you go back and give us again what is the use case?

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

The use case is, and please don't shoot the messenger because I do understand that the use case is not as clear as any of us would like it to be. The use case is to identify disparate care based on different criteria. It's not entirely clear how that is to be done but part of that was based on payer which includes uninsured vs. different types of insurance and I don't know if that means PPO vs. point of service vs. fee for service.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

We're looking for the category of payer not the specific payer like the NVI.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

That's correct and actually having worked for a payer, even under one category there are subsets of coverage that I don't think we're going to be able to get to with any typology. So that's clearly an issue because an HMO, going back to the days when I worked there, is not the same even though it has the same HMO name depending on the employer that modified the plan.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

So you're talking about really plan type rather than payer type?

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Pretty much. Well, it's really payer/plan type. Another words, is there really a payer?

**Clem McDonald, Director, National Library of Medicine**

Could I request that we don't respond to requests that aren't well defined? We can't.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

As much as I would like to do that, we're being pushed to make sure that in all of the 113 measures we now add that. And without something to put in there, I don't know how to add it. That's the dilemma I'm in.

**Unidentified Man**

As a friendly amendment to Clem's recommendation, when we get a request that we can't transact, should we just tell them what we need from them in order to make it actionable?

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

What I can feed back is, assuming that this is their request, using the same typology as, I don't know if UBO2 and... cover the same if they are I can feed that back, and get further clarification from them.

**Clem McDonald, Director, National Library of Medicine**

Someone else is articulating this and they haven't articulating it in a way that we can hear it.

**Unidentified Man**

Good point.

**Unidentified Man**

I think we ought to do our best to tell them what we need from them to do a decent job of this.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Sure and in asking the question, Marjorie do you have, so I don't have to do the searching, X12, UBO lists that I can share with them?

**Marjorie Greenberg, HHS/CDC**

I can email you the URL for the payer typology, yes.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

That would be perfect. Then I can get back to them on that.

**Clem McDonald, Director, National Library of Medicine**

There is also care setting which is well defined and they probably want to know that. That's specified in most records.

**Unidentified Woman**

And they asked to do something with service level, so that's a third arm to that.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Yes indeed.

**Andrew Wiesenthal, IHTSDO (SNOMED)**

Well this is actually good that this is an informed request back to them. Is this what you want as well?

**Clem McDonald, Director, National Library of Medicine**

And maybe they should look at UBO2 too to see whether it's already there.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

There's a UBO4 now.

**Marjorie Greenberg, HHS/CDC**

Right, that's what's being used, UBO4.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Alright, that will be very helpful. I can check that, that's fine. There was a possible request about Socio-economic status – I'm not sure there's a way to identify that easily.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I said in my message back to you and a few people, maybe not everyone on the call, every time you read any health services research study about socio-economic status they tell you which indirect indicator they use to try to ascertain that.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Ok.

**Clem McDonald, Director, National Library of Medicine**

It could be zip code or census tract based.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

It could be you ask people their income level which is very misleading; you could ask them their education level. There are all different ways of doing it but I don't think I've seen myself or been familiar with something that would be a direct vocabulary list of categories that would tell what your socio-economic status is.

**Floyd Eisenberg, National Quality Forum**

That's fine. What that may lead to is the additional criteria from which they would calculate it as additional request. Right now this is where we are, that's fine.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I would say that we probably could find in survey instruments and other ways people who have some standard method maybe even within census or whatever that deals with things like educational level.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Ok, well I definitely need more information from their requestor and we'll obtain that. Thank you.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

So that takes care of patient characteristics for now?

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Yes.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Ok, so as I understood our question about problems, condition diagnosis problems, we were looking for whether there was – where we would find the appropriate width that would deal with severity.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Yes, and in the QDM as we discussed it, we generally have used severity as an attribute.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Yes.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

So that the problem or condition is what it is but the severity would be an attribute and where we did have to apply in the existing tooled measures we went to SNOMED to identify severe moderate - mild, although they never looked for mild in those, but there may be other types of severity that need to be addressed.

**Unidentified Man**

So what's the question of the context of severity? Just general severity of injury or severity of what?

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

It was really the severity of the conditions. In some cases it was the severity of asthma and is it mild, persistent, and we use that as an attribute but at times they just provide the SNOMED code for mild or for persistent asthma. It wasn't necessarily consistent because of the issue of being clear which way to go.

**James Walker, Geisinger**

I would think that we would need disease specific – stratifications may be better than severities, well severities. Asthma has four that are clinically actionable and have guidelines connected to them and quality measures connected to them at least in prospect. Heart failure has four and they would be different and again they are related to... plan, guideline, and undoubtedly quality measures somewhere down the road. Kidney disease has another five. It seems to me if that's what we're after, either at the clinical, actually taking care of the patient level or reporting what's going in the population level and the quality reporting - did you do a good job, that's what we're going to need not a generic severe, moderate, mild.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

No, and that's understood. That's where there were issues of moderate to severe left ventricular systolic dysfunction. That is what we need and it likely is disease specific. That's the advice we're looking for.

**Clem McDonald, Director, National Library of Medicine**

Even better is push back to get the real numbers to make it be that severe and the whole package. You know, injection fraction is one of the core ones with heart failure. I think this may be one we shouldn't do.

**James Walker, Geisinger**

Yes, not if it's just a generic severity.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

There's another issue with adverse effects due to medications. There we need a severity scale but again, that's sort of case specific or use specific.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

**Angiodema** is one thing and –

**James Walker, Chief Health Information Officer, Geisinger**

Right. But that would be based on the reaction that we would be looking for and could be defined. Just like you said, to determine other criteria.

**Unidentified Man**

Well I guess. I'm not sure what the other criteria are that – it seems to me that we probably do need a scale there but that's not on the topic now so I'll shut up.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

No. ok, that's good feedback.

**Unidentified Woman**

I will have someone do a little due diligence about severity attributes or whatever in SNOMED CT and whether they have yet had some that are bound to particular types of problems.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

I know we did find qualifiers that were able to be applied but again understand that moving forward we would like our measures to be more specific using some existing ones where it would have to go back to more detailed evidence to be that specific. It was harder to do that. But I do understand.

**Unidentified Man**

For a lot of these things I think you're going to end up with assessments or survey instruments like the Apache score, now that's a severity score. It's based on 10-12 values or states summed together.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

And that goes back to LOINC to use that and there is a result that tells you what you want.

**Unidentified Man**

Well I wasn't trying to make that point as much – yes, I would agree with you.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Oh, I'm sorry I was solving it with what we talked about the last time, you're right. So I think that covers our need on severity.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

As non-laboratory diagnostic – and this is the one where we ended up with draft recommendations for Diacom which then it said Diacom for images sending of images not coding for the imaging study. But from the vocabulary point of view we were not saying that Diacom made sense.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Right, that's what I heard from the group and I did remember discussion, especially if we are talking about radiology and other imaging studies, that many are linked, there is a link reference and there is also SNOMED, so we are looking for advice there.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

And the other issue that was brought up was 10PCF as to whether its approach was likely to be good for this.

**Unidentified Man**

I think that's a valid question. Is it used yet?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

It isn't used yet but of course we're making recommendations that aren't used yet either. I mean these requirements don't go into effect instantaneously is what I'm trying to say.

**James Walker, Geisinger**

It seems to me that it's a problem lumping images with other kinds of results, eeg's, or pulmonary function testing, or whatever that characteristically produce some numbers maybe some kind of draft and some interpretive comments.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I think you're right Jim and I think this is a point that we've also made that the non-laboratory diagnostic study was kind of like taking characteristics, there was a big lump.

**Unidentified Man**

Jim, the peculiarity, it's not imaging it's radiology vs. – Cardiologist's on the eco's report all kinds of numbers and there will be ultra-sonographers that report all kinds of numbers and radiologist's just talk.

**James Walker, Chief Health Information Officer, Geisinger**

That may be the way we need to say it is that these studies can produce numbers, images, graphs –

**Unidentified Man**

Yes, and image itself are different than the report about them of course too.

**James Walker, Chief Health Information Officer, Geisinger**

Right. We don't need to split it up but just be clear about the components of it and I think the language questions –

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Which of those things is LOINC really good for? Ann, are you on?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

She was on. I would have thought that LOINC was certainly good for expressing giving you a standard representation for the test that was performed right?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Well that's what I was thinking exactly.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

That's what we are really looking for.

**Unidentified Man**

There is like 5,000 going on 8,000 x-ray radiology names and studies in LOINC. There are studies for most of the high level names for other diagnostic studies but I'm not sure it's gotten down to all the granular types of studies in each of the areas in – there's nastography, nastagamograms and emg's and nerve conductions and I'm not sure it's got all the variations on all those things.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Let's put it this way, it has more of them at a greater level of detail than any of the others. With the exception possibly that you can actually describe any type of interventional type of test I guess with PCS.

**Unidentified Man**

Yes, and the diagnostic test too, I think. At one time PCS had over 2 million codes in it, I think they might have simplified it.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

So, it wasn't they had all those codes, it's just that if you do all those combinations you get that many. But it does mean that you can almost express anything in it.

**Unidentified Man**

Well the question is if it becomes the billing code it may – I don't want to say this because it's against LOINC's interest, but it may be an attempting thing to use.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes, and the reason why I was asking about the coverage of LOINC is that obviously we're using LOINC for all of the laboratory diagnostics and so, I don't know maybe it's just me, there's a nice coherence to using LOINC for all other diagnostics that it can be used for.

**Unidentified Man**

Well I'm going to shut up and listen to you Jamie.

**James Walker, Chief Health Information Officer, Geisinger**

I support Jamie. When you think about it from an HIT developer's standpoint or from the inevitable things that healthcare organizations have to do to maintain HIT, the fewer languages that either of those groups have to learn the better results we're all going to get out.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Well irrespective of what happens part of this has to do with – right now if you were going to use something and you were going to use something that people are using it seems to me it would be LOINC.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

If they are using anything, yes.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Right.

**James Walker, Chief Health Information Officer, Geisinger**

Then I propose we recommend LOINC. Seriously, every HIE in the country must be helping its members translate their lab results into LOINC so it's hard to see how you can be an HIE and not be learning how to use LOINC. So then when you try to communicate this kind of thing across that network you're going to be miles ahead of the game.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

This is a question for Clem, are those other diagnostic test names is that considered part of laboratory LOINC or clinical LOINC?

**Clem McDonald, Director, National Library of Medicine**

Clinical LOINC.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

When I look in **Relmak** I can look across both clinical and lab together correct?

**Clem McDonald, Director, National Library of Medicine**

Yes, it's just one database.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

It's one database so it's not as if I'm telling them to look somewhere else.

**Daniel Vreeman, Regenstrief Institute**

I would affirm the suggestion to use LOINC for this phase and comment in terms of the kinds of things that we see in our Indiana patient care. LOINC covers those things quite well. It tends to be many different kinds of radiology imaging studies and those are well represented in LOINC.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

It sounds like we have a direction for these non-lab diagnostic studies.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

The next thing I had on my list as having been referred to us was this notion about the communication and the encounter. Where we were going around here is what was the vocabulary requirement in terms of is it in essence the type of interaction that took place. If you wanted to say somewhere in the record that the clinician emailed the patient or the patient emailed the clinician, what was the vocabulary requirement vs. the fact that you actually had to have documentation in the record somewhere that there was some sort of an encounter. The patient arrived in the office, or there was a telemedicine visit, or an email, or a phone conversation or whatever we were trying to get at what was represented in the structure of would normally be represented as a record within the EHR of something happening as opposed to a terminology requirement.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

There are two things:

1. I know Marjorie Rollins had suggested that we modify encounter to indicate interaction and that was any interaction to describe there was an interaction which might be an office visit or a telephone conversation or a telecommunication email and that way any interaction could solve what we are looking for and that's the act of interacting with the patient.
2. In communication, as we've gone through these discussions, there are certain actions that could apply to that and communication may not be appropriate at the category level but those actions could include transmit, acknowledge, receive, and review, rather than communication as a separate category. How would we state transmit, record, receive? Is there a terminology that we should be using for that?

**Unidentified Man**

Most of the existing data is based on CPT on any of these type of encounters.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

That's correct, it is. For now the ambulatory space in CPT most of the inpatient are based on ICD9 procedures.

**Unidentified Man**

Yes, that's correct. The data is already in existence so why do we want to move in a different direction?

**James Walker, Chief Health Information Officer, Geisinger**

The reason we must move in a different direction is because everything about meaningful use and everything else is about deconstructing – we use encounter as an administrative billing categorization and what we're trying to move toward is a situation where patients and clinicians interact in all kinds of ways, some of them so small and fast that it would be ludicrous to try to bill for them or anything like that. I think the reason people stumble on the term encounter is because it has an administrative billing characteristic. It's sort of the administrative billing aspect of some interactions between clinicians and patients. If we keep those languages and we keep that thought world we won't have any way of accounting for what we are all trying to and are developing and transacting.

**Unidentified Man**

It's more related to administrative so it's not going to impact the clinical side of what we're trying to do. This data is already in existence in the system.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Let me give an example to show what I think is different. There is a fair amount of email going back and forth every once in a while between my husband and his provider. It's really not associated with any bills at all but I think in a lot of environments it's going to be a requirement to have documentation that certain interaction has occurred even if there is no bill associated with it.

**Clem McDonald, Director, National Library of Medicine**

I agree with that 100%. I think the choices is whether to extend the conceptualization of encounter, which is what we did at Indiana, we had telephone encounters, we had every kind of encounter which was just an encounter, rather than getting to a term where no one has any idea what it means.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I guess the issue would be – I would agree with you Clem, whether in effect it is reasonable – we've got 2 things going here. We've got the need to document obviously this type of interaction between a patient and any number of different types of providers. The physical therapist, who knows, maybe the visiting nurse. So, where is the best way? Do one of the existing things that is used to document such encounters cover all of this if so?

**Clem McDonald, Director, National Library of Medicine**

The two ways to go is to make up a whole new concept and reclassify it or extend a concept and sub-classify it.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

That's correct, it is. For now the ambulatory space in CPT most of the inpatient are based on ICD9 And frankly what we understood – I talked to a couple of vendors and I know I've heard others in... has done the same. Many of these vendor systems don't actually identify that interaction type encounter using CPT at all. They only apply CPT when they are doing the billing. The fact that there's been an encounter, using the broader term, is an internal definition so creating the right for it – I don't mind continuing to call it an encounter but broadening the definition. I am just bringing up a recommendation that I had heard.

**Unidentified Man**

Most of the system at this point only that CPT data in some form or shape so there's no option at this point. I don't see any reason to reinvent – you can extract the same information from the data.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Well I think that's because most of the measures that have been retooled are really looking at measures written for administrative data.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

They are still looking at the financial data not at the actual clinical documentation.

**Marjorie Greenberg, HHS/CDC**

We have actually heard from some users that it's actually an interaction – I missed the first half of the discussion – and we would be interested in learning, I think this group would be interested in learning more of how others are representing that information. If you're looking for clinical data and not claims data then I think we really have to examine what the code set is.

**Unidentified Man**

Marjorie, clinical data and encounters are different things.

**Marjorie Greenberg, HHS/CDC**

Right, so the measures –

**Unidentified Man**

Encounters do not represent the clinical in any –

**Marjorie Greenberg, HHS/CDC**

But the whole point of meaningful use is to collect that data from the clinical space and that's the whole point.

**Clem McDonald, Director, National Library of Medicine**

Marjorie, there are two parts of the discussion you missed. One of them is what code set to use and the other one is whether once you extend the name encounter rather than invent a new name.

**Marjorie Greenberg, HHS/CDC**

Right, so Floyd and I have talked about this, if you're truly talking about an encounter from administrative data then –

**Clem McDonald, Director, National Library of Medicine**

An encounter in the normal sense of the word with the patient and a lot of places describe a telephone or email encounter as not as billable.

**Marjorie Greenberg, HHS/CDC**

Right and those are not billable codes. That's the other issue and I think what we're actually looking for when you are actually collecting from the clinical space is more of an interaction. I think historically we've thought of it as an encounter because performance measures were designed originally to collect data from claims but now we're looking at it differently and that's where we are now. If the first half was about what you actually call it I think you can still call it encounter. I think that's difficult to think more broadly about it.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I will mention for example, SNOMED has a letter encounter vs. a telephone encounter vs. various kinds of follow-up encounters. So they do have those under the encounter hierarchy.

**Marjorie Greenberg, HHS/CDC**

I think I might have shared this before, we had submitted some new content to the SNOMED group and we actually had the language encounter and perhaps we didn't define what we really meant and they returned it back to us because they considered that to be administrative sort of reimbursement type of prose and that was out of scope for them. So those kinds of things are there now but I don't think they will be adding additional content that uses the word encounter according to their definition.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

So they will either have to change their definition or –

**Marjorie Greenberg, HHS/CDC**

Well we have to be clear about what we're asking for.

**Clem McDonald, Director, National Library of Medicine**

It sounds like SNOMED has a nice set of codes for –

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Well they currently have those and they have a number of children under those.

**Marjorie Greenberg, HHS/CDC**

From my SNOMED days those are old children. They have been there for a while.

**Unidentified Man**

Old children are good. We're all that.

**James Walker, Chief Health Information Officer, Geisinger**

Floyd has done a nice job defining encounter to represent the new world, so if we say we're going to call it encounter and emphasize that definition when there is confusion, for me the question is it sounds like SNOMED is adequate to cover that and that would be the preferred language? Will CPT be prepared to extend their typology?

**Marjorie Greenberg, HHS/CDC**

Let me just answer this and I have a colleague from CPT on the phone. Our experience in the measure development world is others are capturing that interaction in other ways beyond the terminology. That's something we're going to have to think about. Is it looking for a particular note plus a date and time that establishes that interaction? I think there are other ways to do that if we're actually looking for evidence of interaction between a provider and a patient.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

Just also be aware that this is likely the category it already is that will be used to assign attribution to an individual provider or group. There's going to be a specific measurement performance evaluation that this will be used to say to whom or about whom.

**James Walker, Chief Health Information Officer, Geisinger**

And that will be one of the critical issues. Someone will have to sort it out but if you exchange 12 therapeutic emails with a patient and conduct 3 e-visits, how does that compare with one office visit in terms of attribution?

**Unidentified Man**

Clearly that's going to be a thorny issue but –

**James Walker, Chief Health Information Officer, Geisinger**

We're going to have to capture all the different forms of patient interaction, care, encounters, whatever we are going to call it.

**Unidentified Man**

And that actually opens it up to be able to do those kinds of evaluations, I agree.

**Andrew Wiesenthal, IHTSDO (SNOMED)**

I just want to point out to everybody some statistics. A year ago when I left KP, and Jamie can affirm this, 30% of all interactions with members were via secure messages. So physical and telephone encounters fell.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Right and not billable events. So, Andy we are up from that now.

**Andrew Wiesenthal, IHTSDO (SNOMED)**

Right. So we will have to have the whole country/world will have to have a way of coping with this at the same time there is a gradual flux as how reimbursement is going to flow. My analysis of the conversation is that within an electronic health record system we have to have a way of accounting for the fact that these things have happened which is not the same thing necessarily as things flowing through to a billing system and billing for them.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

The whole model intent anyway could mean that we report any encounter and try to bill for it and we take care of the patient and evaluate on other metrics.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I'm happy to say I think the time for this call is done. That was the list of things that were referred to the Vocabulary Task Force from our first joint call. We have covered them all.

**Floyd Eisenberg, National Quality Forum**

Betsey, do we have a consensus on that last question or do we still need to address it more?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

It sounded to me that we either have to expand the definition of encounter or we have to get people to buy in to the notion of interaction of which a billable encounter as a subset. It sounded to me like people were thinking maybe it was easier to do the former that is, get people to understand that encounters could include things like email exchanges that might not be billed for.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Since those are currently or everything we do is currently in SNOMED, I would recommend that we take that as the starting point.

**Andrew Wiesenthal, IHTSDO (SNOMED)**

And I also take that expanding the definition to whether we would change the name of it or not to any interaction between a patient and any member of a healthcare team, something to that extent.

**Clem McDonald, Director, National Library of Medicine**

Could I caution you on that? Because if I run into a patient at the grocery store is that an encounter?

**Marjorie Greenberg, HHS/CDC**

We probably need to change the word.

**Andrew Wiesenthal, IHTSDO (SNOMED)**

If it's not documented, I don't know about it.

**Clem McDonald, Director, National Library of Medicine**

You just defined it that way.

**James Walker, Chief Health Information Officer, Geisinger**

No you're right, we'll have to say care related or professional or something.

**Unidentified Woman**

I vote for changing the name from encounter. It means something different; a more limiting definition.

**Unidentified Man**

A lot of places are using it in extended but –

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

More people may be thinking about billable encounters.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

If we run into the issue that I think Marjorie was saying about the international folks rejecting new encounter concepts, there's always the US release or the US extension.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I don't have a strong feeling either way. I would say, yes no doubt, there are people who have extended the concept of encounter in their systems to cover these other kinds of things which are not necessarily billable or pass through and then yes there are the people where every time you say encounter immediately think CPT or an ICD procedure code and a bill. I don't have a dog in this fight. I will go with whatever the rest of you think is the right approach.

**Floyd Eisenberg, National Quality Forum Senior Vice President for HIT**

What I can suggest is as long as we are directed toward SNOMED, we can modify this definition and Clem thank you for the clarification, I agree, but the next version of the QDM will be a draft going to the Standards Committee and the public to look at and they can weigh in on the interaction vs. the encounter question at that point too.

**James Walker, Chief Health Information Officer, Geisinger**

My temporizing approach to this kind of thing is always just to say encounter (interaction). We can hasten the expansion of encounter to mean interaction or understanding of encounter as interaction or whatever.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Good idea.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Ok so, that was the set of things that were referred to us in the first joint call. I would have to go through my notes to figure out if there were more that were referred to us from the second joint call but we don't have time to discuss them today anyway.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

So we're back to finishing the spreadsheet next time right?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Yes and I do think we have a joint call for that on the 15<sup>th</sup>.

**James Walker, Geisinger**

That's correct.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

This is good, thank you.

**Operator**

No comment at this time.

**Jamie Ferguson, Chair, Kaiser Permanente**

We are adjourned. Thanks Floyd, Betsey, and everyone.