

Vocabulary Task Force with the Clinical Quality Workgroup Draft Transcript July 15, 2011

Presentation

Erin Poetter – Office of the National Coordinator Poetter – Office of the National Coordinator

Good afternoon. Welcome. Today's call is a joint call between the Clinical Quality Workgroup and the Vocabulary Task Force. As a reminder, this is a Federal Advisory Committee Call so there will be an opportunity at the end for the public to make comments. I'm going to start with a quick roll call; I'm going to start with the Clinical Quality Workgroup members:

Jim Walker?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Here.

Erin Poetter – Office of the National Coordinator

Karen Kmetik? David Baker? Ann Castro? Chris Chute? Bob Dolin? Floyd Eisenberg?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Present.

Erin Poetter – Office of the National Coordinator

David Lansky? Gene Nelson? Eva Powell?

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

Here.

Erin Poetter – Office of the National Coordinator

Phillip Renner? Danny Rosenthal? Joachim Roski? Rosemary Kennedy? Marjorie Rallins?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Here.

Erin Poetter – Office of the National Coordinator

John Derr? Tom Tsang? Jonathan Perlin? John Halamka? John White? Aneel Advani?

Tom Tsang – ONC – Medical Director

Erin? It's Tom Tsang.

Erin Poetter – Office of the National Coordinator

Hi.

Tom Tsang – ONC – Medical Director

Hi, sorry I'm late.

Erin Poetter – Office of the National Coordinator

No problem. Aneel Advani?

Aneel Advani – Indian Health Service – Associate Director Informatics

Present

W

As a reminder to those of you on the phone—sorry to interrupt. Please either turn off or turn down your computer speakers in order to prevent an echo. Thank you.

Erin Poetter – Office of the National Coordinator

Patrice Holt?

Patrice Holt

Present.

Erin Poetter – Office of the National Coordinator

Ken Gebhart?

Ken Gebhart – National Institute of Standards & Technology

Present.

Erin Poetter – Office of the National Coordinator

Great. And now we'll do the Vocabulary Task Force members:

Jamie Ferguson? Betsy Humphreys?

Betsy Humphreys – National Library of Medicine – Deputy Director

Present.

Erin Poetter – Office of the National Coordinator

Clem McDonald?

Clem McDonald – Regenstrief – Director & Research Scientist

Present.

Erin Poetter – Office of the National Coordinator

Stuart Nelson?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Present.

Erin Poetter – Office of the National Coordinator

Marjorie Rallins?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Present.

Erin Poetter – Office of the National Coordinator

John Halamka? There may be some duplicates; folks are serving on two of these committees.

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

Daniel Vreeman – Regenstrief Institute – Research Scientist

Present.

Erin Poetter – Office of the National Coordinator

Floyd Eisenberg? Karen Trudel? Donald Bechtel? Patricia Greim? Jim Walker, obviously. Greg Downing? Chris Brancato? Andy Wiesenthal? Bob Dolin? Amy Gruber?

Amy Gruber – CMS – Program Analyst

Here.

Erin Poetter – Office of the National Coordinator

Ram Sriram? Ken Gebhart?

Ken Gebhart – National Institute of Standards & Technology

Present.

Erin Poetter – Office of the National Coordinator

Lynn Gilbertson?

Lynn Gilbertson – NCPDP – Vice President of Standards Development

Present.

Erin Poetter – Office of the National Coordinator

Nancy Orvis? Anthony Oliver? Marjorie Greenberg?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Here.

Erin Poetter – Office of the National Coordinator

And is there anybody that's on the line whose name I did not call?

M

...

Erin Poetter – Office of the National Coordinator

Now I'll turn it over to Jim Walker.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, Erin. Thank you all for joining. This is, we hope, a great meeting where we maybe, at least, work up—wind up the first save of work identifying vocabularies that are appropriate for the various elements of the NQF's Quality Data Model that we'll all be using.

Can we bring up the Excel spreadsheet, or if you want to look at it on your own computers it's labeled "Code Set recs" (recommendations) 071211v2. It doesn't show up so well on the screen. The first thing that I want to call your attention to is the yellow highlighting that is visible if you have this on—there we go. The—oh I see, the display is bifurcated down the middle so we can't see the QDM section next to the vocabulary recommendations, but if you have the spreadsheet on your computer, the draft recommendations for vocabulary that are highlighted yellow are ones that we've achieved at least near final consensus on. You'll notice that number three, the "Communications," is still under review and we'll need to come back to a couple of things in the yellow highlighted but we wanted to focus today on the ones that are not highlighted yellow; those are the ones that we haven't come to or made at least near final recommendation on and we wanted to finish those and then, assuming that we'll have some time at

the end, maybe take some time to go back and look at a couple that are highlighted yellow, particularly number two.

So if we can go to number ten, "Functional Status," and that's - let's see, it would be - it's not highlighted in yellow, it's probably just a little farther down than that, Erin. No go on down, we'll just have to live without that part—okay, there. So that field that says ICF (International Classification) we wanted to make sure that we had—were comfortable with this one and I—Betsy you help me, but I think the issue here was to be sure that ... we needed ICF in addition to clinical LOINC for functional status.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that the issue was—I think it might actually be since we're using the clinical LOINC for the assessment tools and for sort of individual functions, observations, the ICF was going to be used for sort of a more—a higher level functional status statement and I think the question we had and I know Marjorie Greenberg is on the phone so she—I mean is with us so she can comment on this - is what is the extent—I mean, are people using this now? I know that this is a comment that frequently comes up in the parent committees - just for all of these as to whether this is something that really is in use already or not.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So Marjorie, can you help us with that?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Okay. Well the recommendations of the Consolidated Health Informatics and I think carrying on into the C8 of the HITSP etc., was that LOINC would be used, as Betsy said, for sort of the question aspect, like in a lot of the assessment tools and then when we're talking about the functioning domain, ICF would be the answer as it were. Or just like in some cases LOINC and SNOMED are used together, if that clarifies that. As to the use of ICF, it is very widely accepted throughout the world and used in research and also in a number of other applications in a number of countries. It is not a mandated HIPAA code set but it is the, as it's stated there, it's sort of the only classification or terminology that specifically captures functioning. And some of the components of ICF are in SNOMED and there is a plan between the International Health Terminology Standard Development Organization and the World Health Organization to map the two together but that has not actually been carried out.

The Social Security Administration in the U.S. currently has an ICF Study Group which is seriously investigating whether ICF could be used to allow for more structured data for disability eligibility so it's—I would say that in a sense, if you don't adopt it, it's kind of a catch-22 that if nobody will adopt it—I mean it's already been adopted as a standard, it's recommended by the Institute of Medicine for all disability statistics, so if you say well because it's not in use then of course it won't be in use. So I think for—if we were talking about a HIPAA standard, for administrative standards, I would say no it doesn't meet that threshold because it's not in common use, but as terminology for electronic health records, I personally feel that it is really the only terminology that not only captures domains of functioning but the model of functioning, which has now been embraced around the world which is that it's a biopsychosocial model, not just a medical model and not just a social model, but really captures the merger of those two models looking at activities for participation as well as body functions and structures, and then environmental factors and whether they serve as facilitators or barriers. So I don't know if that is a satisfactory answer without—I can provide more background but—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

No I think that's a wonderful answer, Marjorie. Thank you. Can I ask you one question and make one comment before the question.

I think, I'm pretty sure, that in our discussion the importance of the question "is it in use?" is that we don't want to be mandating standards that no one, anywhere, has ever used and we don't even know if they're usable. So I think the fact that this is in wide use just not in the United States, at least largely or I would think probably entirely ... that concern about is it usable in fact.

The second then is the question, are there any licensing or other issues like that that would complicate making this a standard?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Well this is a—certainly an issue that we in the Library of Medicine have addressed over the years and we have a solution in that we have a five year contract to make it a category four terminology in the UMLS. This is currently under some discussion partly because—in good part because that five year contract had—it was a small amount of money, it was like \$50,000 a year. The National Center for Health Statistics was putting in \$10,000 and the Social Security Administration was putting in \$10,000 annually. But we were also getting \$30,000 from ONC which was committed by Rob Kolodner.

Okay, at that time ONC didn't have very much money but they still committed it for the five year contract but as you know, Rob Kolodner isn't the coordinator anymore; and in fact, nor is Dr. Blumenfeld so we've had a few since then and I think this is an issue that has to be addressed. Because it is a—it's a WHO proprietor of the classification they want it to be widely used. They did not want to have any barriers to its use, but they also need to be able to maintain it. So I think that—I thought we had that problem solved but maybe Betsy can respond here too.

Betsy Humphreys – National Library of Medicine – Deputy Director

I don't know if it's a solved problem yet. But I think that maybe, Jim, we should, I don't know, collect more information and get back or something because this is a lot of time to have spent on this one—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks Betsy. Is everyone else—is there anyone that's not comfortable with sort of leaving this the way it is now and just putting a placeholder that we need more information to finalize it?

Daniel Vreeman – Regenstrief Institute – Research Scientist

This is Dan Vreeman. I'm comfortable with leaving if I can have one brief clarification just from the perspective of physical therapists. There are a couple of dimensions of ICF and the overall biopsychosocial model widely accepted use in medical documents. There's a level of terms that organize the domains so mobility, walking, so forth, those codes are also much more increasingly being used but the next level down of assigning a qualifier that sort of ranks mild, moderate, severe for any of those one things is the stuff that is not used widely. So just as that background I think it is—there's a reason to put it here, but sort of understanding kind of where we are in the rehabilitation field, that's sort of where we are.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks. Comments or reservations about leaving this as is for now? Alright then, let's go on to number 15 then, "Medication." And that—for the slide it's, just scroll down it's a very narrow one, very narrow field and—there it is, it has RxNorm yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

This is Betsy. In all of our calls I think this one doesn't probably need more discussion.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yeah, I think that's fine. Is there anyone that questions that, or can we go on to the next one? Okay, so with RxNorm will be the recommended vocabulary for medication. Then the next at 16 is the "Physical Examination" and the recommendation—

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd. I'd pause here just quick on medications. If we're talking about vaccines as meds, they're not RxNorm from what I heard on our prior discussions. I just wanted to confirm they're CVX MMX—or MVX?

M

That's how I heard it, but—

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Alright, I just wanted to make sure if we're going on that all vaccines will not be in RxNorm. We'll do them in CVX and MVX.

M

Does that include administration of those vaccines?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

This is Stuart. I want to point out that there are lots and lots of vaccines that are not in CVX.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

That was my reason for asking. I'm concerned about that; that was a prior discussion so I'd like to know where to go.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Yeah, well I think that we looked pretty carefully at what kind of crosswalk there is between RxNorm and CVX, and frankly CVX has a lot of concerns about sometimes about dosage, sometimes about route of administration and so forth, and not necessarily very specific about what the actual antigen is so it becomes a little problematic to establish a good crosswalk between the two of them.

Clem McDonald – Regenstrief – Director & Research Scientist

Yeah, we had this discussion, this is Clem, this discussion before and I, I mean you're correct in what you're saying, but the CVX MX is used already widely and they ask for the attributes, including like the lot number which does lock it down pretty well. So the problem is with—do we create some turmoil? I think maybe we should think more about it, if it's necessary but some turmoil if we reverse some of the very successful startup of all immunization messages in the country. And there is this additional information that would be able to clarify the exact details ... it because it's a lot number.

M

That's mandated by CDC.

Clem McDonald – Regenstrief – Director & Research Scientist

Yeah. I might even think we could have chaos if we—I'd like others to speak up. I'm not doing any of that work so I don't know it intimately.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yeah I just want to be sure that if we use that to identify a vaccine and we say in the measure it also says you're allergic to the vaccine, are you allergic—am I using the same CVX value set?

Clem McDonald – Regenstrief – Director & Research Scientist

At allergy level my guess is it would work. Because they're—I'm not an expert. Because it's eggs, principally, isn't it?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well it depends. I mean sometimes it's the eggs, sometimes it's something else.

If we say—if we need to we says substance allergy eggs and we wouldn't say allergy to vaccines but with—if it should come up and it's not clear what the component is then they won't be able to say vaccines.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

My concern in bringing this up was that it's just that there are—I don't think that CVX covers the lot when it comes to all the vaccines that are out there.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

What—this is Jim, what would the alternative be?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Well—I think certainly were you talking about using CVX to communicate about vaccines, it's perfectly reasonable where those vaccines are covered by the CVX but I think if there's not a vaccine that's covered by CVX then I think you're going to have to look for alternative and I'm saying that I think that RxNorm has most of those other ones as well.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, so if we put in that—I wonder if we wouldn't be better off if vaccine was a separate line from medications because it seems—if we said that CVX is the standard code and RxNorm is the backup if it's needed. Is that reasonable?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I think that's reasonable?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Anyone, is that acceptable to everyone else? Any comments or thoughts about that?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well I mean are there any EHR vendors that can comment on whether that would cause any problems for them?

Clem McDonald – Regenstrief – Director & Research Scientist

Well at that, is there anybody from Public Health who is involved with the vaccine programs?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

This is Marjorie. I'm not a vendor or anything. This is Marjorie Rallins. But my question is with respect to the mandate. Is that for mandated for what? For submitting claims for Medicare payment? What's the mandate? Because this is for—

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

My understanding is the mandate is for reporting to a Public Health Registry.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Right.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I don't know that that's the same use case that a measure looks for. A measure is looking for have you given the vaccine. I'm not sure they're the same use case. But that's for...

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

And maybe that's something we might want to think about. Because it seems to me, you know again, I'd like to bring the practical experience, it's much easier to—my recommendation would be to use RxNorm although I do understand the scope of use for CVX.

Tom Tsang – ONC – Medical Director Aneel Advani – Indian Health Service – Associate Director Informatics

But Floyd, this is Tom from ONC. So I think the use case are actually both situations that you talked about, so you have a functional requirement in—at least for stage two recommendation of moving that mandate to report to immunization registries as a functional requirement, and then the measure, I believe, the pediatric—all the pediatric measures is actually have you given the 17 vaccines that you're supposed to receive within the first two years of life?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. As a practical matter when you're running this in EHRs the lot numbers—that's the critical datum because if a lot of the hepatitis A vaccine isn't effective and you need to be able to find who got that and go back and revaccinate them, that's what you're down to. So I think that if you're thinking about meaningful use of EHRs in clinical practice, and by the way probably at least part of reporting that would be important, you really do need the lot number.

Betsy Humphreys – National Library of Medicine – Deputy Director

Well do I understand from what others have been saying—this is Betsy—that in effect what happens today is in a message that transfers this information or transmits this information, the code that's used for the vaccine is CVX but, in fact, another piece of the message includes the lot number?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

You are hearing that but also when I talked to a bunch of EHR vendors they told me they do that only for transmitting externally. They use internal codes for FDD or other codes for the vaccines in their own medication administration section.

Clem McDonald – Regenstrief – Director & Research Scientist

Yeah, that's true of almost everything too much today. So that doesn't really address this question.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

But that was my consideration for thinking to use RxNorm which maps from the FDB for the internal use when you're looking to see if it was done for a measure standpoint, and CVX is for transmitting the two different use cases. So that was my reason for asking the question. And I know it's been discussed but it seems like others are having this issue again.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

One of the practical problems—this is Jim, again—one of the practical problems of running EHRs is exactly the fact that they treat vaccines as medicines. It creates all kinds of practical problems for clinicians and people trying to manage that data.

So, do we—does someone have a proposal then to replace mine. It doesn't sound like mine is quite right.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well I can tell you what we did in the measures that we handled last year and we said either you have the medication as administered, and we used the RxNorm and that was for vaccines, or you have—we called it a procedure performed vaccination we used the CVX. So it gave them the option of whichever one they used. But if we were talking about allergy to, and they wanted to say allergy to a vaccine, we use the RxNorm. That was the convention we applied to avoid having to choose one or the other and that's why—that is a potential to continue.

Clem McDonald – Regenstrief – Director & Research Scientist

It almost seems like we might need more information. Just the idea of going against what is an operational standard in trying to make progress seems complicated. I don't think the allergy issue is relevant because in drug allergies or—you got problems with the vaccine and there's all kinds of problems and they're usually lot related. But I think the issue about whether the systems that are actually recording this are recording this are recording in pharmacy systems, is relevant. Because then it creates—so I don't really know.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yeah, well that's what I understood is using the pharmacy systems to record.

Clem McDonald – Regenstrief – Director & Research Scientist

Yeah that changes the complexion so is there any way we can quickly learn that? In the places that's been allowed but they would record it on a separate piece of paper which got entered in, often into a public health system and what they actually got given. And I didn't—didn't realize the pharmacy was that

involved but I didn't know that they weren't. And would the pharmacy systems prefer one code over the other? And does the FDB not know the CVX codes, for example?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I only know some anecdotal reports when I called around to a number of ambulatory EHR vendors and of the four I asked, three said they use FDB and they do the—they don't use RxNorm either but they were doing external mapping for that or the CVX and one said, "We don't use any codes. We use some internal code and then we map it for whatever people want for interoperability."

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. So maybe where we are right here is that we've identified the issue that we need vocabulary group to address and come to some final recommendation. Betsy, is that reasonable?

Betsy Humphreys – National Library of Medicine – Deputy Director

Well it's a reasonable way to get off this for now—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Well I don't want to dodge it, but it doesn't sound to me like we can resolve it.

Betsy Humphreys – National Library of Medicine – Deputy Director

I'm sorry, Jim. I agree with you. I think that what we're going to have to do is maybe Clem or somebody can email me the specific question we want the answer to, or questions, and—

Clem McDonald – Regenstrief – Director & Research Scientist

I'll try. I think we just need to learn more about the operational realities to settle whether it's going to normally come out of a pharmacy system, probably.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. Thanks. So then—and Floyd, I would recommend that we separate medications from vaccines that way we don't have to revisit medications every time we come back to—

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think that's a good comment. They are meds but meds are also substances in the broad view of things so it's easier because it's a separate terminology or might be it's better to separate it. No problem.

M

And Floyd, how do you anticipate to handle the administration part for vaccines?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well the way the QDM handles it is the category of information is med administration is the state that you're accepting to be in when you're defining it. And then you have to say which med or which vaccine. So frankly the measures, to date, have not been looking for lot number and they have not been looking for any more details than just the vaccine, has it been administered or has it not, and if not, why not? So that now—that's not to say they can't get into more detail in the future.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. I think for quality measures, probably lot numbers are irrelevant. But for internal quality and I would think for CDC it probably would be important to capture it. So, onto the next. So number 16 now is "Physical Examination" and I don't want to over-represent but I believe this is one we had pretty good consensus that LOINC would be the vocabulary for the question or the item observed and SNOMED-CT would be the observation or the answer.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah. And what we need to do is just insert in front of observation, under the SNOMED that it would be for appropriate observations. I mean, obviously, if observation is a—I mean if what is returned is a measurement or number or something, it wouldn't be SNOMED-CT.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right. Thank you, Betsy. So SNOMED-CT for appropriate observation is—do we have any comment or questions about that one, about number 16 - “Physical exam?” Okay. Please feel free but on the ones that we think we’re fairly close I’m not going to spend a lot of time waiting so feel free to speak up.

Then 17 is “Patient Preferences” and here we have, I think, fair consensus, at least, coming into this basically the same as 16, a LOINC for the instruments or forms and SNOMED for the appropriate observations.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think we might want to consider changing our terminology here so observations—a question and answer seems to make sense but question is we usually equivocate that with an observation. Like question and observation are the same or measurement.

Clem McDonald – Regenstrief – Director & Research Scientist

...the value of the finding.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yeah.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Adjusted language?

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah, I think that’s better to. I think we should change that throughout. And while we’re on it I think that whenever we refer to LOINC we should always just call it LOINC. We ended up in some of these previous ones that we went through of identifying Clinical LOINC and I think it’s just better to say LOINC because that is the name of the standard.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Good point. So what is the suggestion precisely? It would say LOINC for value?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

LOINC for observation and you can put parentheses (question measurement) and SNOMED-CT for--

M

inaudible

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Categorical values? Or for answer a result value? That’s not very precise is it?

M

I think where I’ve had some difficulty is I understand to say an observation but then at some ... clinician say, because the observation is what I saw which you would call the answer as opposed to what I did to find what I saw. And I think whatever language we use we just need—having in parentheses question and answer would help, so that—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yep. Is there a reason that we can’t just say question and answer?

Clem McDonald – Regenstrief – Director & Research Scientist

Well some people won’t think of that as a measurement?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, then let's put them in parentheses because I think that's just a linguistic thing. Alright, so what precisely are we proposing so everyone knows? I think for observation (question) SNOMED-CT for value (answer)?

M

Sounds good to me.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Is that okay with everyone else? Obviously we'll send this back out to everyone and if-- ... what's wrong with it or how it could be better, let us know. Alright. So I take it for number 17 then LOINC and SNOMED we think are appropriate. Okay. Then number 18, "Procedure." I'm sorry that one we have landed already. We're not going to do it again. Number 19, "Risk Evaluation" and here the proposal is LOINC—

M

I think it would be—it sounds like that's going to be the same thing as LOINC for the observation measurement and SNOMED for the value, I would think.

M

Yeah, I would guess the same.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It's alright to me. Others?

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Alright. So for 19, "Risk Evaluation," LOINC for the language we picked and SNOMED for the language we picked. Then 20, "Substance." The proposal was SNOMED. Any problems with that? Okay. And then 21, "Symptoms," again the proposal is SNOMED-CT. Any observations or concerns about that? Alright. Then the next one is system—number 22, "System resources," and as I understand it, this category means things like how many nurses do you have, how many beds, other sort of human and physical infrastructure I guess. Is that right?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

It is and I might make a comment. It's possible, just like patient characteristics, they're really talking about system characteristics and perhaps they need to be individually defined because you may want to use different code sets depending on which it is. But I'll ask if that makes sense to folks.

Betsy Humphreys – National Library of Medicine – Deputy Director

Oh, so this is like go back to whomever CMS and get more specificity here?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well this wouldn't be CMS. This came actually out of the—in general, if they want to know, compare nursing staff ratios to--there's no staff ratio to the outcomes of care delivered. They want to know in some cases are there, own how many beds—how many units within the hospital they can provide ventilator service. How many ventilatory beds are there? There are different things but I can't really know what they all are yet but that's the category and so I look for advice on how to move it forward and not have to wait long periods of time when something comes up to get an answer.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So do we have any questions on that?

Betsy Humphreys – National Library of Medicine – Deputy Director

So Floyd, the upshot of this is you may come back with more information telling us what some of the individual ones are likely to be of interest first are?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right. Well we really haven't seen any measures, Marjorie unless you have something specific that relates to it but specifically we've been asked about nurse-staff ratios. We've been asked about durable medical equipment availability, and then the question is if we wanted to say E-Prescribing is available how would we say it? Or wouldn't we say it in a measure? Because RxNorm measures, although they're not endorsed measures that say you can—you use these prescribing in ... percent of your patients, and of your visits, and how what I--what code set what I use to say E-Prescribing and how what I determine that?

LOINC has codes from nursing management and data set for the kinds of things that are like the number of nurses on this unit, you know, you can think of it as an observation or a measurement. And it seems natural for those things that have sort of the question field or measurement-type field that LOINC would continue to expand to cover those things. But if you're looking for like, the list of units in a hospital you know SIU and so forth LOINC's not going to have that list. It could be an answer field but not of elements.

I think we did talk about sort of hospital, we did have the issue of hospital beds and we went back to CDC, they wanted to know how many--not how many, but for every med ICU patient, what was the frequency of central line infections, and then they wanted to know for neurosurgical ICU, and they defined about 20 different kinds of units. So we had to express to them we use the CDC code set, or code list-value set that was basically valid in HL7, so it's the same one. So I assume we would be advised to come back to you and say is that acceptable because we're using it for a national program.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So Floyd, the proposal before the Joint Workgroups is that this be LOINC and HL7 and as you understand better the different use cases, you may come back with additional use cases that those languages don't cover?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right. I mean I think that's the best I can do on this because I don't know what will be required in the future that specifically. But there is a category here. So I think that would help.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Alright. Other thoughts and questions from the workgroups on that? Does that seem a reasonable approach for now?

Betsy Humphreys – National Library of Medicine – Deputy Director

I think it's fine.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Alright. It sounds like we're going to settle on that. And then the last category, number 23 is "Transfer" - there's a lot of language in the fields about deleting context. We're not--that's out of scope for this discussion. We probably are going to streamline the categories but that doesn't need to take our time up right now. So the proposal is that SNOMED is the language that would be appropriate for transfers, and this is a fairly wide, I think category. There could be transfer within a facility, transfer among facilities, transfer across the community. I think we want to be able to characterize patients discharged to home or transferred the hospice or any of those sorts of transfers of either venue of care or level of care. Is that correct, Floyd?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, so is SNOMED-CT appropriate for that category then for transfers?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

This is Marjorie Rallins; it certainly has that kind of content.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. Any demurs, any feeling that SNOMED would not be the best vocabulary we have available or adequate for that? Okay, then I think it sounds to me like we're ready to do that. If I could then, I'd like to take us back to number two, "Patient Characteristics." As you remember, this ended up being sort of a grab bag of lots of different things and so the vocabularies recommended is by far the largest for any of these categories and I just wanted ... a chance to look at this and make sure that it seemed reasonable, you know sort of on second luck. So starting at the top for the patient's preferred language, it's ISO 639-2. For almost all of these we also said that there'll need to be work on a usable--small enough to be usable, large enough to be meaningful subset of practically all of these. But that's for a separate day. HL7 for administrative gender; PHIN-VADS for race and ethnicity; LOINC for assessment tools, such as smoking questionnaires; SNOMED-CT for the language we chose, again that I always think of as answer, SES-- and Betsy or Floyd, you'll have to have to help me with that one.

Betsy Humphreys – National Library of Medicine – Deputy Director

Oh, on the socioeconomic status, we had--we sent Floyd back to confer with CMS about this because, again, they would have to indicate what indicators of socioeconomic status they wanted to use or would be using or people would be using for us to specify what kind of vocabulary would be used because general, there isn't sort of the direct method of determining socioeconomic status. You're usually asking for something else, like educational level or in some cases ZIP code or whatever. So anyway, Floyd went back--was going back to get more information about what was really wanted here.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yeah, and I think what I took from that as well is it may well be determining that is an algorithm defined in the measure from the subcomponents that you talked about. So if you define it as adding different, creating an algorithm based on zip code and income, and if you could define those then those are the elements we would need because this is a roll up of that combined information. And given that then it seems in talking to others at NQF you will see that this is something that will not come back quickly because it has to be a, there would have to be some harmonization about how that should be done to determine the components of it. Unless there's other feedback, I think there that's where that stands.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yeah, and of course some of those are not really problems to the Vocabulary Task Force.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

No. No, that itself is not for the task force it all. It's just if we had to say zip code you could tell us what files to use to define zip code, that's all.

Marjorie Greenberg – NCHS – Chief, C&PHDS

This is Marjorie Greenberg, if I could just interject something?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Sure.

Marjorie Greenberg – NCHS – Chief, C&PHDS

I was at a discussion and we talked about the ACA Section 4302, categories that are relevant to this in our vocabulary call--I think it was earlier in the week, and I was at a discussion of that topic at the HHS Data Consult, and it was acknowledged that this is a requirement under ACA's SES and that they agreed to form a—they had a group that came up with the ones that have now been published for comments, the race, ethnicity, primary language, disability status, etc., and they agreed to reconvene or two convene a new group to discuss what should be captured for SES and again with the possibility of education level and some other things, so I would say that the ball is sort of in their court right now.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

That's great. As long as somebody's doing that then the output of that would inform what would be coming to this group. That sounds great.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Now I will say that their focus is primarily on the standards as it was and what they published for surveys, but it certainly won't form these deliberations I think.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great. Thanks very much, Marjorie. The next one is "Payer Typology." And here we also both identified one of, I forget who it was I'm sorry, identified the ANSI X12 Payer Typology which is in use and we, I think also referred Floyd back to CMS just to make sure we really understood their questions.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I'm still waiting for--to have a discussion on that, but one question I have because if that typology is correct it's basically just a table in that link that we had talked about. On the left side are two-digit codes; on the right side is a message. But I just want to make sure I know which one—what we're actually talking about. I think it's the two digit codes that we would be looking at and the rest is an explanation of what it is. But that's what I wanted to confirm.

Marjorie Greenberg – NCHS – Chief, C&PHDS

You're talking about, I'm the one who--this is Marjorie Greenberg, I'm the one who sent the link to this payer typology and I--

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I apologize. I don't have this in front of me because I'm not online but there was the left- and a right-handed column. And I think HITSP had adopted the left-hand column.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Well it's, yeah - well it's the code with the description.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right.

Marjorie Greenberg – NCHS – Chief, C&PHDS

So I mean the code needs the description, and there's actually a user's guide that gives definitions as well but that's what it is.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Okay. So that's the set of codes that would be used. Okay. That makes sense. And unless I hear otherwise on feedback.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. And then the final one in this group is SNOMED-CT for answers regarding behaviors, resources, preferences, tobacco use, and so forth. So you know I think it's worth just having some time here for anyone to raise any alternatives or issues or questions for this whole set of vocabularies.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well, can I raise one?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Sure.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

It's not so much this, but between characteristics and preference. We do have requests in many measures to look for patients in clinical trials, and we've had a challenge. Do we call a clinical trial a preference because the patient is giving consent to the trial, or do we call it a characteristic ... But whichever category I put it in, I still have to know a clinical trial is in existence for this patient and I suppose there is a generic SNOMED code I can use clinical trial but I just want to know if that would be the appropriate way to handle that?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. I would think it might well be anecdotally the way we identify patients on clinical trials is to create an item for the problem list, so that then it runs against drug interaction checking and those sorts of things. We can use it to compute different patient safety issues--

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

So you count it like a condition, that they're on a trial, right?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

That's the way we treat it, not that that's--

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think it is different in different organizations and SNOMED with cover that for us as well so that's not a problem I don't believe, but I just want to make sure--

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Any thoughts on that specific question?

Betsy Humphreys – National Library of Medicine – Deputy Director

If Marjorie doesn't know the answer, I think we should determine whether there is actually a distinction, whether there is something that in SNOMED-CT that really means a clinical trial participant as opposed to a distinct concept which is the clinical trial itself.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I don't know what class it's in but I think the exact description is clinical trial participants.

Betsy Humphreys – National Library of Medicine – Deputy Director

Oh, okay.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Because we've used that. But the challenge we've had on some inpatient measures, they want to know that the trial was specific to the condition that's being measured, and that required the subject of the trial to be that condition, and I'm just not sure how feasible that is to--

Betsy Humphreys – National Library of Medicine – Deputy Director

What you ought to do is we ought to be promoting that people carry the NCT number of the trial the patient is in.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yeah, that would be great.

Betsy Humphreys – National Library of Medicine – Deputy Director

Then you could go—then that would be a detectable fact from clinicaltrials.gov.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I like that. I like that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

That would be great.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I don't know if we'll be able to implement it too fast but yeah I like it.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

This is Marjorie. Regarding your earlier question, I think you are asking Marjorie Rallins, correct?

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Okay. This multiple clinical trial with associated concepts and SNOMED, some discussed the status, some identified clinical trial participants, so I think, you know, there's content there and as I've mentioned before there is also an avenue to add that content. But I also like the proposal just discussed.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Oh, yeah. And I think the ones we used were participants, and it could very well be a condition as opposed to a characteristic. It's just--I don't know that it's standardized, how it's stored and managed in EHR so we have to accommodate.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Right. I agree.

Aneel Advani – Indian Health Service – Associate Director Informatics

This is Aneel Advani. I'm wondering, for the issue of whether a patient is on a clinical trial or not, whether the categories, Floyd, that the two options are the only options? I mean, is there a possibility to create a category of like clinical context and then use that for elements such as the person is participating in such and such a clinical trial or other types of clinical context like if there's something about comparative effectiveness, or if there's some sort of precursor event that needs to exist for this to be measured, where it's not where it's not just easy to put in as a straightforward denominator...

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yeah, so what we actually have done on that--you raise a very good point. We created attributes to manage the context but we might not have an attribute called clinical context. I think we had reason or justification. But we could certainly, I mean adding that as an attribute for a context of the statement, I think, may make more sense than making it a separate category of information.

Aneel Advani – Indian Health Service – Associate Director Informatics

Or you could just combine them and just keep an accounting of attributes in the category for clinical context, and then we can at least identify places where we don't have standards or if the HL7, you know, the sort of formulation that ... the way that kind of formulated that. That may be appropriate as well.

Clem McDonald – Regenstrief – Director & Research Scientist

Hey Floyd? The clinical trial business is really an important question in a lot of context but it's very complicated. It'd be great if every order in a hospital, they knew whether this was ordered or related to a clinical trial because of complicated billing and legal issues and all that. It's been really hard to get any of that known because the clinical trial context may be specific to an individual order not the patient.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

No, I understand that. That's why we—yeah, I understand.

Clem McDonald – Regenstrief – Director & Research Scientist

There was some interest--there was, actually there was a recent message in HL7 that had a field in the order as proposed where it would say what clinical trial exactly and I don't think that's been used very much. So the question is, is where do you collect it and then you might--is that a registration field we should push into the registration process and how do you do it? It isn't just a free-floating attribute.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

No, I agree. And I don't know the answer and I don't think this ... and it's—I don't know the Vocabulary Task Force can answer that, but I think it needs to be answered.

Clem McDonald – Regenstrief – Director & Research Scientist

Yeah, I would actually push for--I would actually push for somebody to have a place to put that in the context of an order or result or admission or whatever. And probably you'd like to know which study too, because they can even be two trials, studies, at the same time sometimes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Clem, you are right. This is Jim again. That's part of why we make it a an item on the diagnosis list because then it can be associated with specific orders or--

Clem McDonald – Regenstrief – Director & Research Scientist

Oh, okay. Oh yeah. So that may be the answer then.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Well, at least it's one possibility. Okay so I just wanted to say that we're doing very well on time by the way. We have, I think, half an hour left and we do have another agenda item and public comment. But I just wanted to sort of take a moment and give everyone an opportunity if there is anything we've discussed that needs some more comment or whatever, now is the time.

M

Hey, Jim, ... here.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I'm sorry? I'm sorry I didn't understand that.

M

... here. I want to make a comment.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Oh yes, please.

M

About the encounter. I mean at the last call we were discussing about the encounter and the communication and stuff. And I think still that's sort of an outstanding issue about what to use in--we were sort of, when we ended the call I mean it was still an open issue.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So this is number seven, "Encounters?"

M

Yeah. And then the communications were like encounter with your doctor on e-mail and all that. Remember that?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yeah. So go ahead, make your comment.

M

So my comment was when we were discussing about that I mean my understanding was like CPT was... and all the system at this point for any type of encounter transactions, and we were sort of--we talked briefly about expanding some of the things which are kind of not, at this point, present. So I just wanted to kind of redo that and see anybody have any comment or do you have any thinking about that?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I'll take the first shot and I'm sure Betsy, Floyd, or Clem or others, can fix what I mix up. I think our conclusion was that we wanted to--the reason we have it here is as (Encounter) any patient-professional interactions is because it's our belief that particularly going forward, but already in the present, we are expanding the concept of encounter to include all kinds of interactions between patients and one clinician or another that have not historically been called encounters, and certainly haven't been treated administratively and in payment systems is encounters. And so I think the thought was that three and seven "Communication" and "Encounter" understood as a wide range of interactions have ... overlap and that SNOMED was better suited to enable us to capture all of the different kinds of interactions that need to be accounted for, both for new internal meaningful use and for reporting, so--- others?

Or maybe want to respond to mine if people are willing to leave that as a fair representation of the discussion.

Betsy Humphreys – National Library of Medicine – Deputy Director

This is Betsy. That's how I understood it as well.

M

Okay, thanks.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd, I agree.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Did you want to comment to that, ... ? We want to be sure we've got this as clear as we can.

M

Yeah, I was just thinking along the lines of most of the existing data is based on CPT and all the encounters related to any transaction is based on CPT, so if the issue was related to like expanding what's missing, I think that can be handled and that's where, I mean, I thought we sort of stopped last time. So that's why I wanted to make sure, I mean what was the conclusion?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I don't know who on the call could talk to--it sounds to me like SNOMED could do more of it better but I'm--it's way beyond my—

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I could say in, when we talk about procedures a similar issue came up and to say that it's a continuum of kinds of things that can be done as encounters are basically a continuum of kinds of interactions that can occur, and that if they were specified in SNOMED to map down to SNOMED from that to say, which of the billing that billed encounters actually would capture what we're looking for could be done. But the other thing I have heard from some EHR folks and I think I remember from my vendor days is that the interaction that actually occurs is stored internally within EHR and only--the CPT only comes into play

when a bill is created. But the EHR has a concept for encounters as separate from that and it might be more consistent with what SNOMED can deliver.

M

My sort of, my thinking was more like okay, it's coming into play when the billing is done but it can still be used on the front end too without being used as the billing agent. Because the data is the same; it's just repurposing for one purpose rather than using for the reimbursement.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well sure, that would be making it a clinical terminology and not just a billing terminology which I understand—

M

Exactly. Exactly, that's my point. I mean just to—

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

But it would also need to then---if we were to do that, my question to the Task Force is would we be using two code sets to manage this; one basically for physicians and one for everything else, and including physician non-billed items or would we be expecting CPT to expand to cover all of the eventualities that we're going to need for the future?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. Part of my concern with that, ... is that we try very hard and I'm guessing most care delivery organizations do to treat the clinical reality as the core reality and obviously we have to cope with billing regimens to get paid and so we do, but you end up with a lot of information and other problems if you treat the billing convention as the core reality and I think, well think it's clearly HHS's intention that that the billing reality changes fundamentally over the next...years. I think that's part of the point of this ACO is that it becomes, you know, it's not fee-for-service anymore its fee for reportable quality and savings and ... partly with me, I would think that CPT is destined to become progressively less important if what HHS and ... happens and all.

M

And exactly that's my point like on the clinical side, that's 100% correct, but on some of these encounter-related, are kind of not really clinical I mean you're more talking about the communication side than actual clinical sort of encounter with the other physician you or I want to see, so the relevance of slightly different if you're talking about clinical diagnosis intervention site versus these kinds of sort of areas that are sort of in an open area whether it's clinical or not.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd. I think as I listened to this I'm kind of thinking that the term encounter which is the question, should we actually delete that term and call it interaction? What we're really looking for is the interaction which is a kind of procedure has occurred between two individuals, like when a clinician and a patient's and it's not all doc, it's not all nurse, its physical therapist, it's many others and you might even want to know was there a use in a broad sense encounter between a church-based group and a patient in order to evaluate for dietary needs, and it's not even a clinician at all. And so that's where I think SNOMED is able to handle that broader piece and it's not really just the fact that all measures in the ambulatory side use CPT to identify it, because the retool, to the extent they could be using existing terms, and they were based on claims and we're moving away from basing on claims. That was the reason, I think, for thinking of SNOMED.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

You're right—this is Jim, Floyd, you're right. One of the things that we're starting to do is use lay coaches and lots of other people are as part of the care team so that I think the definition of interaction is a better term.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think the other issue on encounters is a little beyond the task force's charge but will need to be considered is in many cases they're used to indicate that attributions to any individual clinician when you're looking at performance, and in that case attribution may not have to be tied just to something generates a claim, but could be applied to many things. I don't presume to have any real handle on how that should be done, I just think we need to—IT needs to be able to provide the data from which that could be determined.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

This is Marjorie again, and I just wanted to add in and might've mentioned this in one of the last calls that we've been doing some querying of vendors I can't share who those are at the moment but perhaps ... in interaction or encounter more broadly is not--is happening in other means beyond terminology and I think we discussed that as well. It's a date and time stamp plus something else and it could be SNOMED as well, so I just wanted to, you know I thought of respectfully disagreeing with ... who I have enormous respect for, but I think that presently what's happening is that the clinical encounter is being captured more broadly.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

And I do want to address something Clem said last time, I don't think--and I agree, we don't want to necessarily capture the serendipitous encounter that occurs in the grocery store because you see your patient there. But we're talking about clinical interactions.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Rather than administrative.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Are there any other comments or questions about ... Okay. Any other questions or issues about the 23 sets of recommendations taken as a whole?

Aneel Advani – Indian Health Service – Associate Director Informatics

This is Aneel Advani. I have one potential issue I'm not sure if it is but I'm wondering if the way that SNOMED, because of the tremendously greater expressive power of both coordinated expressions and sort of the possibility of evolution locally, expression using the sort of tools of SNOMED, whether the way that SNOMED has used the vocabulary is sort of fundamentally different enough from what we've been used to, that we should be addressing kind of when we sort of select SNOMED, the type of use we're talking about or some sort of like annotation or understanding of how SNOMED would be used as a category. So are we talking about that in the standards or ... care.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Good point.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

And you say in applying at last year we were I know we had a lot of advice from some of the folks on this phone including Marjorie Rallins about making sure we were consistent there, so I recognize that. I guess we didn't have that specificity to the task force yet.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great. Great point and we'll definitely need to keep that in view. Any other? Okay I don't have the agenda in front of me because of some kind of computer snafu but I believe the next part of the agenda was Betsy and Karen Kmetik were going to talk about a topic that escapes me. Betsy?

Betsy Humphreys – National Library of Medicine – Deputy Director

On the agenda, Karen had suggested that we talk about just an update on the availability of vocabulary mappings.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

And she was, had provided—Karen, are you there?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

She was going to be driving she said and I guess—

Betsy Humphreys – National Library of Medicine – Deputy Director

Alright. So she had sent a few notes about this essentially just to alert people and I think we probably should maybe get some more background on this and send around a message or something. Just that there are mappings from, and Marjorie probably knows about this as well, from SNOMED CT to CPT. There's a rules-based cross map there that's available from the AMA, and with the purpose of providing associations between SNOMED CT concepts and CPT descriptors and I gather, I'm reading from her notes, that this includes CPT category one and three codes, ... code, for the best represented SNOMED-CT concepts and NLM has been involved with earlier work on a LOINC to CPT map which is not, at the moment, in a particularly updated form but we hope will be in the future. So, I think probably what we need to do is send around some—and there is a project that is becoming front and center for NLM to map SNOMED-CT to ICD-10-CM so these are tools that are going to be helpful that are going to be available relatively soon.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great, thank you.

Betsy Humphreys – National Library of Medicine – Deputy Director

Or are today.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay. Thanks. I don't think we have any other business before the Workgroup's Task Force.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Hello, this is Marjorie.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Hello? This is Marjorie I was disconnected and I apologize when Betsy was asking the question about the maps, do you still need my response?

Betsy Humphreys – National Library of Medicine – Deputy Director

Marjorie, I was able to read the notes that Karen had sent me.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Okay.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think I've covered it.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Okay, thank you.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So are there any other issues and concerns from the workgroup or task force or should we go to the public comment?

Pam

Jim, this is Pam. I just had one minor correction within the spreadsheets. On number 13 for the inert ingredients, it's going to be RxNorm. There was some confusion in perfecting the flowsheet so there are not options within SNOMED, so that will just be corrected to read inert ingredients will also be RxNorm.

Betsy Humphreys – National Library of Medicine – Deputy Director

Those, thank you Pam, those who are familiar with the current state of RxNorm may know that inert ingredients are not in it but we are going to—Stuart and his crowd are working on adding the inert ingredients just as ingredients, not linked in. So that, in effect, RxNorm can be the source of the allergens for people who are allergic to inert ingredients, as well as active ones.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you. That's super. Okay, I think then, Erin, we're ready for public comment.

Erin Poetter – Office of the National Coordinator

Great, operator can you let us know if there's anyone on the line who wishes to make a comment?

Operator

I do have a public comment.

Carol Bickford – ANA – Senior Policy Fellow

Thank you very much. Carol Bickford of the American Nurses Association. I have one comment and one question. The comment is in relation to transfer and you've identified this as being a change in location or a service; is it also intended to accommodate the transfer to a different caregiver? So that it would address a change of shift reports, both for the registered nurse as well as physician as well as other clinicians as there is the changeover. And the question I have is where would you have the discussion about plans and outcomes? Terms that are very important as we're moving to new ways of doing business.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Floyd, do you want to respond to that question?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Actually the first question was an interesting one because it hadn't come up yet in the context of the measures about transfer of service or individual. It's something we just have to look into how to describe that but yes, we would need to—sounds like that may be important. It will be important.

The second question, I apologize – I was trying to find the mute button and I didn't hear it because I'm working on a cell phone.

Carol Bickford – ANA – Senior Policy Fellow

The second question was when will the concept of plan and outcome be incorporated into the discussion? Particularly in light of our new way of doing business?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yeah, and the challenge we've had on that is to figuring out where to incorporate that and what we have done and I think we've discussed in the Clinical Quality Workgroup that the category called "health record component" is probably in need of a clearer name. It's really the structure of the record that we're looking for and that's where the concept of a care plan is, the component that we'd be looking for that is there and the care plan, at least as it's currently defined in this model, contains related conditions, interventions, or in ... we call it the broad spectrum of features. The expected outcome and the actual outcome and the outcome can be expressed by one of the other concepts, so the outcome could be a weight change, it could be a lab has changed, it could be a perception change so it was hard to identify since anything that could be an outcome is identified by one of the other categories how to re-express that all within the plan and we felt the plan would use the other categories of information within it to express expected outcome or goal and actual outcome or achieved outcome. Does that help?

Carol Bickford – ANA – Senior Policy Fellow

Sort of. Thank you.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

It's something that ...

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. Just very quickly on the first point. I want to support that. I mean we are trying to manage now things like transfers from an inpatient care manager to a home health nurse or to an outpatient clinic or to an outpatient care manager. That's another, I think, another place where our efforts to provide patients all the care they need across all the transitions is going to mean that there's a whole set of transfers that become critically important that we'll categorize.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

And I agree. It's transfer and not just of location. And it's just—we will look at how to best express all of those as we look at our next effort, the QDM that you will be receiving in September, and the Clinical Quality Workgroup to look at.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

More public comment?

Operator

You have no more comments at this time.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Alright I guess if we don't have any other business I'll thank you for what I think was really productive meeting and we'll get a report out then all of the recommendations and we'll be making recommendations to the Standards Committee Wednesday.

Public Comment Received During the Meeting

1. Jim--I am no expert, nor am I a vendor, just a practical guy. There may be uncovered vaccines, but that should be a spur to development on the part of the industry. We should use the standard (CVX) and where there are gaps rapidly fill them. I like your proposal--use CVX and RxNorm as needed. The need will shrink with time.