

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

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good afternoon everybody and welcome to a joint call, the Vocabulary Task Force and the Clinical Quality Workgroup. This is a federal advisory call and there will be an opportunity at the end of this call for the public to make comment.

I will do a quick roll call: – Jamie Ferguson?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Walker?

James Walker, Chief Health Information Officer, Geisinger

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Betsy Humphreys? Clem McDonald? Stuart Nelson? Is anyone on from NLM?

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Rallins?

Marjorie Rallins, American Medical Association

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

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

Daniel Vreeman, Regenstrief Institute

Here.

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

Donald Bechtel? Patricia Greim? Chris Brancato?

Chris Brancato

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Andrew Wiesenthal?

Andrew Wiesenthal, IHTSDO (SNOMED)

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Bob Dolin? Amy Gruber?

Amy Gruber, CMS

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Ram Sriram?

Ram Sriram

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Lynne Gilbertson?

Lynne Gilbertson - NCPDP

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Greenberg? Sarah Ryan?

Sarah Ryan

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Karen Kmetik? David Baker? Ann Castro?

Ann Castro

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Lansky? Jean Nelson? Eva Powell? Phil Renner? Andy Rosenthal? Joachim Rosky? Rosemary Kennedy?

Rosemary Kennedy

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Tom Tsang will be a little late joining the call. John White? Aneel Advani? Did I leave anyone off?

Asif Syed

Present.

Donald Bechtel - Accredited Standards Organization X12

Here.

Anthony Oliver

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you.

Ok, I will turn it over to Jim Walker.

James Walker, Chief Health Information Officer, Geisinger

Thanks Judy. Our business today is to we hope finalize code set selections to serve for the quality data model and get those ready for presentation to the standards committee on 17 August and finish all but comment.

As you know our task was to assign vocabularies to the fundamental concepts in the quality data model. We reported our work to the standards committee on 20 July and I think the report was well received. There were some useful questions that came up and they've been built into the agenda and so what we have here in the next set of slides is just the outstanding questions we need to address to put together the final report. All of the vocabulary recommendations that we had agreed on and that the committee didn't raise any issues with are not in this slide set. I hope that will help us focus on the decisions that we need to make to finish.

Just for clarification, one of the things the standards committee reporting context helped with was to focus on the fact what is in the scope is identifying vocabularies for reporting of clinical quality measures. It would be better obviously if those vocabularies were also useful and useable inside organizations for their internal management but there is no requirement implied in any of this that those organizations would use the vocabularies we're identifying for their internal work only for reporting clinical quality measures.

One question I think we need to address is identifying standardized vocabulary standards for exchanging information for MU2, is that also out of scope for this set of work and something we may well need to come back to but not something we're concerned with today? Floyd or Jamie or whoever might be the right people to address that question.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

My question comes from a comment made at the standards committee by Doug Fridsma that some of the measures require structured data that may imply structured data input for clinicians, and that was a concern. I would also question if there is a look-back or we're measuring – and some of these measures require information that may come from other sites, if there isn't structured information exchanged to get that information from other sites in a structured manner, then it won't be there for the one physician or organization being measured to be able to use it in any way for the measures.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Right, I was going to chime in somewhere along the same lines the aspect of standardized information exchange that I think logically could be in scope for this, would be data that could potentially be used in subsequent reporting of standardized measures by the recipient of the information exchange.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

So I think we said the same thing basically.

James Walker, Chief Health Information Officer, Geisinger

Other comments or questions? So, Jamie and Floyd, is the wording on the slide in the blue font the way to say that or is there a better way to say that?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I would say standardized information exchange of data that may be used in quality measures.

James Walker, Chief Health Information Officer, Geisinger

Ok.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

That would restrict it to this particular scope.

James Walker, Chief Health Information Officer, Geisinger

Is it ok if we said data needed for quality measures?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Fine by me.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

The only risk with that is since we don't know all the data that is required for all the measures because they are not all written yet, that can potentially create a large scope, but I agree with the statement but it's hard to know what that is yet.

James Walker, Chief Health Information Officer, Geisinger

Right. Do you think that uncertainty goes beyond just the natural uncertainty of all of this that we're inventing the wheel – we're trying to describe the wheel while we're inventing it? Do you think its any higher risk than any other part of this dynamic system?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I don't think so but –

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

No, I don't think so at all.

James Walker, Chief Health Information Officer, Geisinger

Alright, then it sounds like unless there's further comment, we will say standardized information exchange of data needed for quality measures. One of the things that came up very strongly in the meeting is we want to make the usefulness and usability of the vocabularies we choose as wide as possible but the requirements as narrow as possible.

And then out of scope to make sure we are in agreement, is intra – inside the organization information management and reporting to other external entities for other purposes. Any concerns about that?

Ok, then let's go on to the next slide. This is nothing more than my attempt to try to put in some kind of structured shape what I think are the criteria that all or many of us have in our heads as we are trying to identify the best vocabularies for each of the quality data model data categories. I don't think there is any requirement that we agree on this it's just meant to be useful if it is useful although if anyone has a comment, it would certainly be welcome. But this will not be representative of the joint workgroup's conclusions.

Why don't we go on to the next slide. I think we have about 6-7 questions. The first one is probably the hardest question to form. In our last work group meeting we concluded that the question about socioeconomic status wasn't well enough formed that we felt comfortably we were answering what they were asking and Floyd I think you were going to get some clarity on that for us.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Yes and the answer to that was this is not in scope for this current progress. So, when that's determined we will look into it.

James Walker, Chief Health Information Officer, Geisinger

Well, that was simple. Thank you. Is Pam Cipriano on?

Pam Cipriano

Yes Jim, I'm here.

James Walker, Chief Health Information Officer, Geisinger

Ok, so you got that. CMS says that socioeconomic status is out of scope.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Now there were some questions that Tom Tsang may have and Pam may be familiar with them, not about socioeconomic status but about some of the characteristics and whether the recommendations from this group were in line with OMB recommendations for certification. I wasn't sure how to answer that. Pam do you have that?

Pam Cipriano

I don't think we have an answer yet.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Ok, so that's being evaluated.

James Walker, Chief Health Information Officer, Geisinger

Let's move on to payer typology, the 2nd major sub-bullet. Floyd did we get any clarification on that?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I think the only thing that was asked in response was to make sure that it was optional and as long as it's able to represent what's listed is fine. I did also hear from Don Bechtel regarding a response from X12 on that and I think there had to be something to acknowledge that it came from there. I'll see if I can find it.

James Walker, Chief Health Information Officer, Geisinger

Floyd, are you saying that CMS believes that ASC, X12 and the payer typology are appropriate?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

What I can say is – I'm trying to go back and find the note –

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Don is on the call.

Donald Bechtel - Accredited Standards Organization X12

I'm on the call but I'm not sure I understand the question yet.

James Walker, Chief Health Information Officer, Geisinger

The question was proposed at the last work group meeting that ASC, X12 and the payer typology would be appropriate vocabulary for defining payer typology and I believe we agreed that we wanted to ask CMS if that was their understanding.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I think your response to me you sent from Margaret Walker was that the appropriate attribution has to be applied. I'm not sure how that would happen but –

Donald Bechtel - Accredited Standards Organization X12

Yes, only on your documentation. I don't know if I can say what CMS would approve but I believe the typology would be appropriate from my perspective.

James Walker, Chief Health Information Officer, Geisinger

Alright, other people on the call either support or question the appropriateness of ASC, X12 or the payer typology for this?

Lynne Gilbertson - NCPDP

What is payer typology and how does that relate to patient characteristics?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Well, here is the use case. In order to be able to look for appropriate care, care not disparate based on patient factors, they wanted to know for all patients for whom the measures are appropriate. The payer, so it could be identified to see if there was any disparity in care. That was one of the areas, another was ethnicity, and the other was race. That's where that came from. I don't know if that helps you Lynne?

Lynne Gilbertson - NCPDP

Thanks.

James Walker, Chief Health Information Officer, Geisinger

I apologize that we didn't have the typology in this meeting's materials. We went through it a little bit in the last meeting and it didn't occur to me we would need the typology again.

Marjorie Greenberg, HHS/CDC

I think during the last call or the call in which I brought up this typology which is an external code set approved by X12, I did email a link to the payer typology but I'm not sure everybody got it.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

You did, its www.phdsc.org and then an extension from that.

Marjorie Greenberg, HHS/CDC

You can find it on the Public Health Data Standards Consortium website.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

One question that did come up from CMS and I do need to check – maybe Don knows this, they want to know if the patient has no insurance and I think self pay covers that.

Marjorie Greenberg, HHS/CDC

The typology covers that.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I think that's listed under self pay as the element.

Marjorie Greenberg, HHS/CDC

It might even be more detailed than that.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

There's another one that says free care.

Lynne Gilbertson - NCPDP

Marjorie, just as a question, did it appear that when the code set was created that it would handle pharmacy benefits or is it more intended just to relay the medical benefit category or such? I'm trying to find the email to look it up.

Marjorie Greenberg, HHS/CDC

Certainly a lot of people get their pharmacy benefits through the same insurer that they get their other health care benefits. I would, of course, have to defer to use to the extent to which it meets those needs. Now, the thing about the typology is there is a coordinate and maintenance committee and is updated at least once a year and I think if it's essential, it can be update twice a year as well. Early on it didn't capture everything the DoD needed and so we added all of those. If it doesn't completely meet all of those needs then it would be appropriate to do so; it can certainly be updated.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Lynne, you are raising a good question because that didn't actually come up in the use case and I don't know if that's desired but it's a good question to take back to CMS.

James Walker, Chief Health Information Officer, Geisinger

I think the normal shape those reports and studies take is limited to payer rather than – for one thing it would be a second dimension and you'd end up with a very large group of different combinations of medical payer and PBM.

Marjorie Greenberg, HHS/CDC

It depends on the data model I guess but as I said it could be added if it's not currently – I have a question about what I thought I heard Floyd say about when he talked to CMS and they said something about it being optional. For each of these is there an optionality included in all of them? I'm assuming race, ethnicity isn't optional.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

No, what they want to ask for is in the report out of the patient level data they want to make it optional so if at the moment they are asking for it and it's not there, they are not saying you are going to fail on the measure.

Marjorie Greenberg, HHS/CDC

Oh I see. Whatever their policies are or whatever the standard is.

James Walker, Chief Health Information Officer, Geisinger

I think in scope here is if a quality measure were to include identification of payer type this would be the typology that would be used. I have to admit it's hard for me to imagine in which case that would be part of a measure. I think what Floyd is saying is they wanted it included almost as sort of in case down the road.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

It was actually to be included to send that information along with every measure not to be included in the measured calculation but just to be provided that there is insurance or what type.

James Walker, Chief Health Information Officer, Geisinger

Any other questions about the appropriateness of the payer typology for use in this? Whether ACO's would be considered payers, I'm guessing they wouldn't but they didn't exist when this typology was written. Have you addressed this to CMS at all Floyd?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

No I didn't.

James Walker, Chief Health Information Officer, Geisinger

Would you just document that you've asked them about it. If we come back a year from now and they decide it's needed, it would have been smart to start getting a put in. if not, then we ought to drop it.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Ok.

James Walker, Chief Health Information Officer, Geisinger

I guess the proper way to express this Marjorie is payer typology (ASC, X12).

Marjorie Greenberg, HHS/CDC

Well, the maintainer of the typology is actually the Public Health Data Standards Consortium. If you request X12 to update that they are payer typology, they would refer you to the Public Health Data Standards Consortium. It's an external code set approved by X12, but they don't maintain it, the Public Health Data Standards Consortium maintains it.

James Walker, Chief Health Information Officer, Geisinger

Pam, did you get that?

Pam Cipriano

I think so.

James Walker, Chief Health Information Officer, Geisinger

Ok then on to slide 7 if everybody is ready. A question was raised on that first point in terms of patient professional interaction previously known as encounter. SNOMED was widely accepted as the standard vocabulary, the question was since so many organizations are used to using CPT codes to identify currently existing and reimbursable encounters whether CPT would be acceptable for MU2 with the proviso for MU3 it would not be acceptable any more.

Ram Sriram

What is going to happen to the data in MU2 then?

James Walker, Chief Health Information Officer, Geisinger

Well that's why we are having this discussion. Yes, that's a good point.

Marjorie Rallins, American Medical Association

The overall notion that I heard from the meeting was transition for organizations not just for this data element but for others. Did you hear that as well?

James Walker, Chief Health Information Officer, Geisinger

Yes and I think it was in another of the groups reports and there was explicit discussion of the need to give organizations time to respond. And particularly in this case where it is in very wide use and in the short term most of the encounters that would be relevant would probably be in CPT.

Pam Cipriano

We've begun some discussions and Floyd has been helping us think through this together with the Standards Interoperability staff at ONC. We believe there does need to be a transition plan and this does raise one example where this might be helpful.

Andrew Wiesenthal, IHTSDO (SNOMED)

I hate to say the following thing but I think this is actually might be true. Almost everybody is figuring out right now how to move from ICD9 to ICD10. A part of that is to understand how to keep measures that are based on ICD whole across the transition and it may be the strategies that they are creating, organization by organization to do that, would actually be reusable across the transition between CPT and SNOMED. Just as a footnote to this discussion, I think we ought to ask someone to see if they could explore that because whatever we do and whenever they make the transition they are going to have the same problem.

James Walker, Chief Health Information Officer, Geisinger

True. Ok.

Pam Cipriano

Karen Kmetik has shared in the past that AMA has done some of that mapping between SNOMED and ICD9 and ICD10.

Ram Sriram

SNOMED to CPT.

Andrew Wiesenthal, IHTSDO (SNOMED)

SNOMED to CPT, exactly. I don't know if Marjorie is there or who's there but it's under contract to the NLM.

Ram Sriram

No it's an independent AMA product.

Andrew Wiesenthal, IHTSDO (SNOMED)

No but the NLM also.

Ram Sriram

That was from CPT to Loink.

Andrew Wiesenthal, IHTSDO (SNOMED)

Well I'm not going to dispute it but it also involves SNOMED.

Marjorie Greenberg, HHS/CDC

Is CPT the only administrative that is acceptable under meaningful use 2? It was my understanding that ICD9CM or 10CM are not acceptable under meaningful use 2 but only SNOMED. I'm a little confused by this.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

You're talking about what was recommended by this committee in our last couple of calls?

Marjorie Greenberg, HHS/CDC

Yes. I know in meaningful use 1 you had the option of SNOMED CT or ICD9CM and then after 2013 it was supposed to be SNOMED CT and ICD10CM but then I thought this group had decided it should only be SNOMED CT.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

The original recommendations for problems were 9CM or SNOMED for meaningful use 1. 10CM or SNOMED for meaningful use 2 and SNOMED alone for meaningful use 3.

Marjorie Greenberg, HHS/CDC

Ok and is that still the recommendation?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I don't think that has been changed.

Marjorie Greenberg, HHS/CDC

Ok.

James Walker, Chief Health Information Officer, Geisinger

I had not been aware that it had been either.

Marjorie Greenberg, HHS/CDC

Then that was a misunderstanding on my part.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I'm thinking of an analogy from some of the work the vocabulary sub-committee has done recently in making recommendations for RX Norm where the recommendation specifically said that the entire vocabulary or a certifiable or testable portion of it should be used in EHR certification essentially immediately or the immediate next rule making. Then the measure is based on the use of that should be later. So, in effect the certified technology would be sure to have the capability of using the coding system and have some time for implementation before eligible hospitals and professionals were measured on its use. We may want to think about that idea here as well.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

That was part of the discussion that Pam Cipriano brought up about a transition for meaningful use 2 to accommodate that. In our prior discussions in this group it was looking for each of the QDM categories of information moving to a single code set but it didn't accommodate for any transition.

Ram Sriram

There was some discussion about the CVX too.

James Walker, Chief Health Information Officer, Geisinger

On this one, any other pros, cons on whether CPT should be acceptable for interactions or encounters in MU2 but not 3?

Ram Sriram

It's going to depend on the transition plan. If there's a plan on the right way to transition it then it's an acceptable strategy, if not then continue as it is.

Andrew Wiesenthal, IHTSDO (SNOMED)

I would ask the same question for - because CPT is often referred for physicians or ambulatory but for the inpatient side would ICD10 be something to consider as well.

James Walker, Chief Health Information Officer, Geisinger

I'm sure the case that was made for CPT was that everybody is already using it and that would substantially decrease the burden of change if they were allowed to use it a few more years and change everything else and not have to worry about that right now. ICD10, that's not the case.

Marjorie Greenberg, HHS/CDC

CPT actually has codes for types of encounters doesn't it?

James Walker, Chief Health Information Officer, Geisinger

It does. Part of the consideration is it's probably not adequate as we change our idea of what patient professional interaction is.

Marjorie Rallins, American Medical Association

This is where my concern is. With respect to the transition I certainly appreciate that we've expanded the definition of interaction. My concern is if we recommend, not just for this particular data element for any other data element, if we recommend administrative code set, not that we shouldn't, does it send the message that there's no need to necessarily change. That's what my concern is. We recommended CPT for those who wanted to expand or use a different level of granularity to express that interaction, they have a way to do that. In speaking to Jamie's comment, in having vendors begin to use these code sets now that sort of fosters and helps the transition - I'm just throwing that out there.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Thank you Marjorie. Let me mention another idea along the lines of a different approach to transition that we could consider. The recommendations themselves would be for single code set, basically the ultimate target would be a recommendation in every case. But then we would also have as part of our recommendations that there need to be a transition plan that may include the interim use of basically what's being used now.

Ram Sriram

I think that's the recommendation at this point.

James Walker, Chief Health Information Officer, Geisinger

In that proposal Jamie what you're suggesting is we take CPT out of here and just say for all of these categories -

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Right, just have a more general recommendation of the needs about transition planning, but there would have to be case by case considerations as to what that means.

Andrew Wiesenthal, IHTSDO (SNOMED)

I agree with that. I think it makes it simpler for people to understand.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Let me say a concern about that. I have no problem with that here but as measures are currently being created for meaningful use 2 if they only use SNOMED CT and only provide that then you're forcing beyond the transition. So, if you don't actually provide a transition plan so those measures can include alternate terminologies or alternate code sets that could create some concern later on.

Andrew Wiesenthal, IHTSDO (SNOMED)

I tried to express this perhaps poorly before. That precise statement could be applied to any measures that were dependent on ICD as of October 2013.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I agree.

Andrew Wiesenthal, IHTSDO (SNOMED)

There is no allowable use of 9 past October 2013 and everybody's going to have to figure out how to measure the things the measuring longitudinally across that inter-sketch, if you will.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

It's just creating an additional requirement that hadn't been previously indicated in 13 and previously was indicated more for 15.

Ram Sriram

I think it should be documented until we have a plan and then have ample time in-between like what we have for ICD at this point, 3 years in between to plan and implement it.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

What I'm suggesting is it's more about how it's presented. So we have a set of recommended vocabulary targets and that's essentially a single ultimate target in each case. In terms of a separate recommendation for transition plan we can call out areas where we anticipate there could be transition issues and any amount of content could be put into the transition plan recommendation. It doesn't have to be nothing it could be quite substantial but it wouldn't then detract from the presentation of the set of target recommended vocabularies.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I'm perfectly fine with that. I like the idea but the question is if measures are being written starting today for that purpose –

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Right, the measure developer would have to consider both the target and the transition plan segment as applicable.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

But without a specific guide for the transition –

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I guess what I'm saying is if there are cases as we go through this where we have ideas about what the transition plan should be we should put those in the transition recommendation.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Ok.

James Walker, Chief Health Information Officer, Geisinger

I think from a measure developer standpoint they would need to build a measure with SNOMED CT in this case, and the measure developers would have no obligation perhaps to do anything about CPT but it would be possible for vendor organizations to say, we're going to use the NLM mapping from SNOMED to CPT and we'll go ahead and send it out in CPT because we have to do that anyway.

Marjorie Rallins, American Medical Association

From a measure developer standpoint, some of the AMA PCPI workgroups are beginning to think about how to express their measures with the now additional vocabularies available to them. I don't necessarily see an issue with the transition from a measure developer standpoint.

Andrew Wiesenthal, IHTSDO (SNOMED)

I frankly don't either and my concern is on the implementation side and how much push back there will be.

Marjorie Rallins, American Medical Association

I can appreciate that.

James Walker, Chief Health Information Officer, Geisinger

So, the question would be if the measure developer develops it in SNOMED and the implementer wants to implement it in CPT then there would need to be a mapping. Then the question is whose responsibility is the mapping? Is that accurate?

Marjorie Rallins, American Medical Association

Yes, well there is a map that already exists.

James Walker, Chief Health Information Officer, Geisinger

And so if that were part of the transition plan that Jamie is talking about and you said look, the developer develops in SNOMED and if you want to implement it in CPT, here's the mapping that you would use to do that and know that you are accurate. Would that work?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

That's exactly the kind of thing I had in mind. I don't know if we have in hand a list of all those transitional recommendations but that to me would be a cleaner presentation of our recommended target vocabularies.

James Walker, Chief Health Information Officer, Geisinger

It sounds like we have a growing consensus to do what Jamie said. To list SNOMED CT for example here and then develop some language that talks about what would be needed to support transition plans for specific ones of these categories where they are relevant. Does anyone want to speak against the proposal that we just say for patient professional interaction encounter the vocabulary SNOMED and we develop other language that we put in elsewhere that talk about supporting reasonable transitions?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Let me ask specifically Marjorie Rallins, does that deal with your original concern about introducing the use of administrative codes into new measures?

Marjorie Rallins, American Medical Association

Yes, I think that this plan we've outlined works.

Maggie Lohnes

I've joined as an invited guest of Dr. Tsang and I don't know procedurally if it's appropriate for me to comment now or wait for public comment time?

James Walker, Chief Health Information Officer, Geisinger

Judy? I think we would welcome the comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, if it's relevant right now go ahead.

Maggie Lohnes

Just a brief introduction to the pop-health project we're doing with ONC is to have a reference implementation to model the implementation issues with everything from certification process through to measures. The only comment that I would offer is CTC codes are required for billing purposes so they will always be included in the EMR. If they aren't included in the code set or be measured that nature demands a crosswalk within an EHR system so, there will be mapping whether it's required or allowed in the measures.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

Thank you Maggie. In this particular case, this is actually a good place to talk about that because we're talking about encounters that are not billable. One of the things we looked at on our last call that SNOMED has very good robust representation for as a lot of those non-billable encounters that occur today for which CPT would not be used in that way.

Maggie Lohnes

Ok that makes sense.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

But then it does enable, where CPT is used, the cross mat that we're talking about as a recommended transition strategy would enable those to be used for the measured representation as well.

James Walker, Chief Health Information Officer, Geisinger

Thanks Jamie. Ok any other comments, thoughts? Let me ask again, do we have consensus that for patient professional interaction encounter our recommended code set would be SNOMED CT and we would have other language that would reference ways to manage that in terms of providing mappings and existing vocabularies to be used for some transition period of time.

Marjorie Greenberg, HHS/CDC

But that would only be used for meaningful use 2?

James Walker, Chief Health Information Officer, Geisinger

Yes, I guess. We may not want to specify it that closely in the language and leave that to the transition planners. I think that would be the idea, yes. Again in the nature of things, it might be that one transition was longer than another for one reason or another.

Ok, we will go on to functional status. An issue was raised at our last work group meeting that ICF – I think the proposal was roughly, although I sharpened it a little bit, that ICF serves a necessary function not served better by LOINC or some other vocabulary. It's unfortunate that Betsey's not on, is there anyone who can speak to this knowledgeably?

Marjorie Greenberg, HHS/CDC

The question I see here is: Does ICF serve a necessary function not served better by LOINC or another vocabulary? I think yes it is definitely not served better by LOINC. I think I mentioned in the last call when we were talking about ICF that there has been discussion about "LOINCafying" ICF but that has not been done. Its assessment tools and questions, etc. are in LOINC but LOINC is not a substitute for ICF, certainly not now. If all of the ICF codes with the qualifiers were mapped into LOINC codes that would be another story but that isn't the case. Right now there isn't any work going on to do that. The other alternative would be SNOMED which certainly covers body functions and structures pretty comprehensively but does not currently include all the concepts in activities and participation or in environmental factors.

Again, there is a plan, which Betsey has confirmed as well, to map between a WHO and **IHCSDO** to map SNOMED CT to ICF but it's after the mapping to ICD10 has been completed so I don't think funding has been identified so down the road it may be that all the necessary concepts will not only be in SNOMED but also in the conceptual model that is more like ICF. I don't know what the plans are on that but right now there really isn't another terminology that covers all of the concepts for functional status and disabilities that are in ICF.

James Walker, Chief Health Information Officer, Geisinger

Just for clarity the question about the necessary function, it's your sense that it does serve a necessary function.

Marjorie Greenberg, HHS/CDC

I believe so.

James Walker, Chief Health Information Officer, Geisinger

Ok, thank you very much. Any discussion on that?

Daniel Vreeman, Regenstrief Institute

I would agree with what Marjorie said. It does serve a unique function that is not exactly easy to describe on these calls but it is a unique function that is not covered by what LOINC does and there's certainly a way to think about it and relate them as covering distinct spaces. The additional comment I would add I think in this category we should also probably add SNOMED to our list in the same way we've done it in other domains where you think about LOINC as being appropriate for the question or observation or measurement and where applicable, values or responses to those questions could be coded in SNOMED. So a functional status assessment that's formalized might have graded responses that would be appropriately represented in SNOMED.

James Walker, Chief Health Information Officer, Geisinger

Ok, thank you. Others?

Rosemary Kennedy – Thomas Jefferson University

I definitely agree with everything that has been said. There are gaps in SNOMED, some of this is not in LOINC and I do think that ICF is needed and serves a strong functional goal.

James Walker, Chief Health Information Officer, Geisinger

So, it sounds like we believe that ICF for categories of function, LOINC has stated and SNOMED for –

Tom Tsang - ONC

I have a question for Marjorie. Did you have a chance to look over section 4022 report from the secretary in OMH on data standards to reduce health disparities and looking at disability standards as well? Would SNOMED have the symantec capability to capture and represent those recommendations?

Marjorie Greenberg, HHS/CDC

I looked at those and did not as it says based on the conceptual model of ICF. There are very few questions of course and so it is possible that SNOMED – it could be mapped with SNOMED codes. I can't answer that because I don't have the questions in front of me but they are pretty general. Is that all that this functional status is supposed to be? Just the response to those questions?

Tom Tsang - ONC

No, I'm just thinking ahead that report is out in public domain and sooner than later we probably are going to have to have vocabularies and code sets in place at some point maybe not for stage 2, but just thinking about the future of representing those clinical concepts and to being people up to speed. Section 4032 of ACA that is generating a set of recommendations from the secretary to reduce health disparities and the work group came up with recommendations for what standards to use for race, ethnicity, language, disability, and sexual orientation and so –

Marjorie Greenberg, HHS/CDC

They are investigating sexual orientation. There were no standards named for that. Actually let me try to make a clarification here which I think I tried to make the last time also. The section 4032 recommendations that are out for public comment until next Tuesday or something are for surveys not for electronic health records.

Tom Tsang - ONC

That's correct.

Marjorie Greenberg, HHS/CDC

So if you were going to look at functional status in the clinical environment or for the electronic health records those questions, obviously would not be adequate. They are more for using disability as a demographic.

Tom Tsang - ONC

You are absolutely right and I'm just thinking of the broader context of when researchers are using electronic health records, surveys and also for the broader use of CERV research. I think in terms of extraction for data if you think about building the foundation for some of this stuff, we should think about it now instead of downstream 5 years from now and say we don't have the vocabulary for that type of work but yet –

Marjorie Greenberg, HHS/CDC

I'm not quite sure where this intention was going when somebody added SNOMED. Are we still talking about ICF or not?

James Walker, Chief Health Information Officer, Geisinger

The proposal evolving is ICF would be for categories of function, LOINC would be as stated on the slides and SNOMED would be for appropriate responses.

Marjorie Greenberg, HHS/CDC

Is that what you were suggesting –

Daniel Vreeman, Regenstrief Institute

That's what I was suggesting. I'm thinking of standardized assessments of physical function –

Marjorie Greenberg, HHS/CDC

I could see SNOMED as – couldn't ICF also be used for the responses?

Daniel Vreeman, Regenstrief Institute

It depends if they use the same qualifiers. I'm thinking of things that are ranked or graded or describing different characteristics. Typically the question-answer model holds and right now we didn't – I don't know of any specific assessments that would have ICF codes as answers right now but I'm thinking of some that might have SNOMED.

Marjorie Greenberg, HHS/CDC

I thought that the residual – the SSA ones, SSA was talking about using ICF in the responses. If you were to ask somebody a question in an assessment related to some of the environmental factors, I'm not sure SNOMED would capture them at this point.

Marjorie Rallins, American Medical Association

The only point that I would make with respect to SNOMED and the answers is I believe it does have the semantic structure and operational process to address the gaps if that's where you wanted to go.

Marjorie Greenberg, HHS/CDC

I think what the consolidated health informatics recommendations were LOINC for the questions and the vocabulary for the responses could be SNOMED or could be ICF. I'm not quite sure how you're pigeon-holing ICF right now and saying it's for the categories. What did you mean? I didn't understand that.

James Walker, Chief Health Information Officer, Geisinger

It was my attempt to capture Dan's language, maybe he should respond to that.

Daniel Vreeman, Regenstrief Institute

The way I would view the relationship of all three of these would be ICF would be perfect for saying this patient has a severe difficulty walking and so that translates into an ICF code for walking, the activity walking and with 2 different qualifiers I could say they have this severe difficulty even when they use their cane. That's the performance aspect and the capacity is it's even worse when they don't use what's available to them. But in order to make this assessment of this person has difficulty walking I might do a couple of things: I might measure their gate speed, I might do an observational gate analysis and look at if they have balance problems. Those measurements/assessments particular characteristics that LOINC is great for like a measurement of a particular function. You roll those up into a category or a more aggregated concept of difficulty walking. So where does SNOMED fit in? The reason I added it was in the same vein of these other domains where we say answer lists to questions are probably best represented in SNOMED. If an answer to a question is how often do you walk a mile and you answer sometimes rarely or never, those types of answers could be codified in SNOMED. That's where I was going with that. Does that fit with what you were thinking?

Marjorie Greenberg, HHS/CDC

It kind of depends on the question.

Daniel Vreeman, Regenstrief Institute

It does, right. That's why I –

James Walker, Chief Health Information Officer, Geisinger

That's the idea. If you said how does the walking difficulty localize? Is it ankle weakness, knee weakness, instability, hip curdle weakness, those might all be SNOMED codes I'm guessing.

Marjorie Greenberg, HHS/CDC

They probably are in the body functions and structure codes of the component of ICF. You can get level of detail and you certainly can in SNOMED as well. So, it really does depend on the question.

James Walker, Chief Health Information Officer, Geisinger

Is it your belief then Marjorie that ICF would do those responses as fully as SNOMED for this domain?

Marjorie Greenberg, HHS/CDC

Not probably at the body function and structure level because ICF is essentially a classification and SNOMED of course is more granular. But as Dan said before, it uniquely fills this space of functioning and disability. Currently I don't think either – not LOINC but even SNOMED doesn't capture all of the concepts.

James Walker, Chief Health Information Officer, Geisinger

I think from everyone that has talked so far thinks ICF has a role.

Daniel Vreeman, Regenstrief Institute

Right, so let me go back to the question that started this second round of discussion which was 4302 standard. I think the question there was is this something SNOMED represents. We can apply the same three level approach might be appropriate but I just pulled disability status on the web and you'll see a question like because of physical or mental condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? The responses are yes or no. That's exactly the kind of question, very much like another assessment or survey question could be represented in LOINC and the responses

of yes or no you could choose to code those with another terminology or use default codes for that. But that is a question type thing that is represented pretty well in LOINC structure. Other parts of those things for example, ethnicity, you would want to look at a different terminology form, but as far as the question under that disability status thing, they sort of fit the questionnaire model.

Marjorie Greenberg, HHS/CDC

Under LOINC, I would agree because they are pretty high level questions.

James Walker, Chief Health Information Officer, Geisinger

Back to the decision we need to make, it sounds like we agree that ICF is necessary for categories of function, LOINC is necessary – what is the group's feeling about SNOMED and its necessity in this? It sounded like 2-3 people felt it would be needed, is there any counter to that? Are there people that feel it would not be needed? We're going for minimum necessary obviously.

Marjorie Greenberg, HHS/CDC

I guess the goal is to have only one target terminology but I could see aspects of functioning particularly at the body functioning level that would be very comprehensively captured by SNOMED. I think it's appropriate to include it as well.

James Walker, Chief Health Information Officer, Geisinger

Ok. Is there anyone that wants to speak against including ICF, LOINC, and SNOMED in functional status? Ok, let's go on to slide 8 then. Thank you, great discussion. I hope we feel like we've come to a reasonable consensus there. It's hard to tell on the phone.

In the last meeting we had put vaccines along with medicines as being expressed by RxNorm. The point was raised before the standards committee meeting but was raised forcefully there that organizations currently use CVX to report vaccinations to public health and other entities and that it was probably the appropriate language to use for vaccines. First, Tom, Pam, and Floyd, you can correct my representation of that but then we need to discuss whether vaccines need to be separated and expressed in CVX or if it makes sense to leave them in RxNorm under medications.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

The main reason for considering RxNorm in the past was in order to address when you're dealing with allergy or adverse effect and that's the reason why not to give the next dose of vaccine then would CVX still work there. If it wouldn't work there then that would be a reason to suggest something else. Also if we were looking for the fact if you were searching your chart to see if it was actually administered or if there's a record of it, would you find it? You probably wouldn't find it in RxNorm either, but would you find it in medication terminology or in CVX?

James Walker, Chief Health Information Officer, Geisinger

Ok and that's one of the things that raised the scope issue particularly clearly. I think the fact is at least many EHRs treat vaccines as medications for the reasons Floyd announced and I believe use RxNorm in that context. It is also the case that at least for organizations that report vaccines to public health agencies – I was talking to one state immunization registry operator and he said as far as he knows all state information registries, and he seemed fairly knowledgeable and definite, all require CVX for vaccination reporting. It sounds like the case is most organizations or at least many are currently using both vocabularies to characterize vaccines.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I believe if the recommendations of the vocabulary group for the use of RxNorm are followed because of the branded package as well as the generic package as well as the semantic names being included in those recommendations; it seems to me that those are generally more specific than what's used in CVX. So I don't know what's needed from a measure standpoint.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I'm not a measure developer but often measures are looking for the number of doses given to date as of a certain age and which vaccines were given. They are often also including, unless there's allergy to it or

adverse effects from it, if they can they specifying which adverse effect they are looking for in which case they are looking for a condition or some other occurrence and that wouldn't require the name of the vaccine. Or if it's a component like **eggallumen** then that would be looking for **eggallumen**. It's just the question of what does the doctor put on the allergy list. Do they put egg or do they put influence of vaccine?

James Walker, Chief Health Information Officer, Geisinger

Someone else was going to comment?

Maggie Lohnes

I was just going to give the experience of our implementation test of three different sites which sounds that they are using CVX, CPT codes, RxNorm, or one of the contributing languages of RxNorm which is allowed by the meaningful use certification definition.

James Walker, Chief Health Information Officer, Geisinger

If part of our intention is to enable information exchange I'm guessing that meaningful exchange of vaccination information will pass through state immunization registries probably rather than CDC, although I'm not sure of that. If that's the case I guess CVX would have the advantage of being the language that that exchange will almost certainly be conducted in. Comments on that?

Marjorie Greenberg, HHS/CDC

I think that's a reasonable assumption.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I would agree. If for interoperability to public health that is what's occurring and if they are going to the local registry or state registry to identify prior vaccines that may well be what they are receiving it in. My question is how would you want us to represent if a measure developer decided to put allergy to that vaccine? Would they be using CVX in that respect? Or is there a map from that to the actual med?

James Walker, Chief Health Information Officer, Geisinger

Others? Any wisdom on this one?

Maggie Lohnes

What we found at all three of our pilot sites is that they were using egg as an allergy rather than vaccination.

James Walker, Chief Health Information Officer, Geisinger

To stir the pot we have got to put our nickel down at some point here.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I think what I just heard is that CVX would be the one to list but my only concern is when I heard the transition ideas that came up earlier, is there a map from that if anyone did use a medication code and I'm not sure one exists but it does to CPT clearly, I know that.

James Walker, Chief Health Information Officer, Geisinger

Does anyone know how organizations currently turn their internal activity into CVX codes?

Maggie Lohnes

Our experience is that they often have the documentation lists the vaccination which sends out behind the scenes into the appropriate billing and documentation codes.

James Walker, Chief Health Information Officer, Geisinger

I take it that nobody knows a solution to the problem that RxNorm enables you to treat vaccinations as medicines which in some cases is useful – there's no language that lets you do that and communicate across your organization's walls it sounds like. Is part of the recommendation that someone produce mappings from RxNorm to CVX?

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I think that would be consistent with the points we've been discussing as part of the transition plan for this section.

James Walker, Chief Health Information Officer, Geisinger

So are we comfortable saying that the vaccines – the standard language for measure developers express vaccines in CVX? Any comment? Ok.

The next is my question but sort of goes to what Dan said earlier. We have a typology of LOINC for questions roughly speaking and SNOMED for appropriate responses. It just occurred to me looking at our report that we didn't have that in risk assessment and I wasn't sure that we had discussed it and decided that wasn't appropriate here for some reason.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I think when we talked about functional status we said this would apply for risk as well. When we had our discussion we didn't specifically say it here but I think it was intended here but I will leave that to the group.

James Walker, Chief Health Information Officer, Geisinger

Any comments on that?

Daniel Vreeman, Regenstrief Institute

That seems right to me.

James Walker, Chief Health Information Officer, Geisinger

Anyone else want to pro or con? Pam, you got that will just be the same and we will document it here so it's clear and I don't have to forget it again.

Finally, on system resources we have LOINC and HL7 but again I had forgotten what we said each was for.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I thought I recalled LOINC for personnel resources such as nursing, number of nurses – Dan, you know what's in LOINC regarding those resources but HL7 for everything else.

James Walker, Chief Health Information Officer, Geisinger

How would we express everything else in a narrative?

Daniel Vreeman, Regenstrief Institute

Good question. I'm not sure – I know LOINC has the complete thing for what is called the nursing management minimum data set which is those kinds of things that Floyd alluded to number of nurses on this unit and so forth but I don't know the whole space of system resources involves.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

So this is a generic concept in QDM but if there was a desire to know the number of ventilators available or the number of oxygen available beds in a facility or some other resource. I'm thinking of hospitals but this could be in the community as well and we just weren't sure where to identify those concepts of this is a resource, this is a ventilator. Now that may be a device, you can call it that but the resource is for how many are there is what this is about.

James Walker, Chief Health Information Officer, Geisinger

Would it be reasonable to say LOINC for human resources and HL7 for devices?

Daniel Vreeman, Regenstrief Institute

First, I'm not sure and maybe someone can enlighten me, not sure what codes HL7 has in this space. Are we thinking that it's a function of knowing which messages are sent back and forth which will tell you some kinds of information? LOINC would be perfectly happy to make a code that describes the number of CT machines you have because it's an observation about something and we have observations about populations and units, etc., but I'm thinking there are some other parts here that I'm not understanding.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

One of the challenges about looking at the general concept is we want to know resources within a community or system that many haven't been defined yet because the measures haven't been written. It's really difficult I understand to come up with the right code set to do this. We can certainly have an interim of LOINC for everything that we are aware of if that's an appropriate place to ask for these terms to be.

Daniel Vreeman, Regenstrief Institute

If you need a count of something, that makes sense. If what you're saying is we're going to pull the inventory list and see what's there, then those inventory items aren't going to be in LOINC.

James Walker, Chief Health Information Officer, Geisinger

So are you recommending then that for system resources we just say LOINC and leave HL7 out?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I'm just having trouble thinking of the specific use case other than those because it was mostly nursing resources what helped bring that up or an account of are there available devices, it may not be a count but, is there a device...

James Walker, Chief Health Information Officer, Geisinger

Even with the case of nursing resources Floyd, I guess I'm not entirely clear how that would figure into a clinical quality measure.

Unidentified Woman

There are endorsed measures looking at nursing resources and staffing and potential impact on outcomes.

James Walker, Chief Health Information Officer, Geisinger

In the existing meaningful use measures?

Unidentified Woman

No not in the currently retold meaningful use measures but endorsed measures that are out there that are already endorsed. I don't have a specific use case that was put forth but there are endorsed measures looking at resources and outcomes. I don't know Floyd if LOINC is enough or it's a combination of LOINC and SNOMED.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I have the same concern and frankly one of the major areas for looking for measures for 2013 and 2015 is resource use. It's not the highest on the list but there's a look at resource measures now. I don't know what they are going to need to identify what the system resources are and are they present. If they're present, what's the difference in outcome? We don't have them defined enough yet to say exactly what we'll need.

James Walker, Chief Health Information Officer, Geisinger

Maybe it is not wise for us to propose a standard vocabulary when we don't understand the use case.

Pam Cipriano

Let me read the definition that we were working from that Floyd would have provided on the earlier spreadsheet: the configuration of an organization maintain nursing staff ratios, availability of durable medical equipment, health information technology, infrastructure and capabilities such as e-prescribing, access to care systems or invasive procedure capabilities.

James Walker, Chief Health Information Officer, Geisinger

Thank you. If you're doing structural measures you'd have to have that but if we're moving beyond and we have an EHR, we have a neurovascular surgeon or a nurse for every 5 patients, etc. to actual performance and outcomes, my question is how much are structural measures going to be part of the evolving landscape and what we really actively measure going forward?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I can understand that I just think it goes a bit beyond structural because we might see a definition of given certain structure what's the outcome.

James Walker, Chief Health Information Officer, Geisinger

That's an important research question but is that a clinical quality measure?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

If there's evidence. All I know is this was a request for a need and part of it was based on the need to determine what went into meaningful use stage 1 even that were not endorsed measures but just measures of use of IT to know is IT present. The QDM was developed to accommodate measures such as that whether they are measures for meaningful use or not the QDM had to be able to accommodate it. I leave it to the team whether or not to address it, if you don't when developing the authoring tool we'll have to put something in there if a measure developer decides to include it. Something has to be there as an option. If it's not a recommendation from this group it will be from whatever information we have.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I don't have it in front of me but do you recall what coding systems were used in the HITPC emergency response use case where a lot of those different kinds of systems resources were coordinated? So, one institution there would be a message to ask another institution about resources that were used.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

For that it was HAVE, Hospital Availability Exchange from Oasis.

James Walker, Chief Health Information Officer, Geisinger

Is there a reason that would not be appropriate here Floyd?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

For types of units within a hospital or organization, that would be appropriate. Perhaps the answer is this is something in some ways similar to patient characteristics where depending on what resource we're looking at there might be a different taxonomy or a different code set. I think HAVE would apply for that but I don't think it would cover everything. I think that's a reasonable approach. Thank you for reminding me about that Jamie.

James Walker, Chief Health Information Officer, Geisinger

What is the minimum necessary set of code sets for system resources? It sounds like we need LOINC and we think HAVE and LOINC and HL7 don't overlap. They address fairly distinct –

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

HL7 does have types of ICUs and they were developed by CDC and run through HL7 and there are 2 current CDC measures that have been retooled. They are looking at stratifying care across the 20+ different types of ICUs. They have used the HL7 lists which originated with CDC. That's a little bit different than HAVE that would identify all ICUs I believe the same way or close to the same. They are not identical.

James Walker, Chief Health Information Officer, Geisinger

Pam, I don't remember, have we required HL7 for any of the other data categories?

Pam Cipriano

I can quickly look that through. I don't remember off the top of my head.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I believe on our last discussion on this it was to go to CDC as the source since they originated it although HL7 is the one that validated it as an SDO.

James Walker, Chief Health Information Officer, Geisinger

My concern is that we're recommending 3 code sets for system resources.

Pam Cipriano

The only thing that I found is the sinbads which is a source for HL7 under characteristics. There is no other specific HL7.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

Right, and sinbads would also be a source for this.

Pam Cipriano

I'm sorry under health records components we do have HL7 for the messaging between systems. That's the only other one.

James Walker, Chief Health Information Officer, Geisinger

LOINC both have to be able to deal with HL7, so the question for me at least is does HAVE provide enough value that it's worth saying here's a third one that you will have to be able to deal with?

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I honestly don't know the current status of HAVE. That's going back about 8 years since I had those discussions. I think if we can deal with its greater granularity in the HL7 lists that came from CDC. If we can address that they can be fairly easily mapped to HAVE if people are using it. I don't think that's a problem if we don't use HAVE.

James Walker, Chief Health Information Officer, Geisinger

Pam, what do you have for our recommendation here? LOINC for what? And HL7 for what?

Pam Cipriano

As stated right now we have LOINC for specific staffing resources and HL7 for devices and system capabilities and I'm not sure I have the definition for the HAVE system.

James Walker, Chief Health Information Officer, Geisinger

I think it would be a mistake to add another vocabulary in the absence of a clear use case and absence of anyone on the call knowing exactly what it would contribute.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

I think I also heard HL7 for facilities and the presence of different types of facilities. It sounds as if perhaps, Floyd, it might be appropriate in the transition section to address this particular item to say that there may be a need to mapping from HAVE to HL7.

Floyd Eisenberg, National Quality Forum Senior Vice President for HIT

I think that's terrific. That would help a lot.

James Walker, Chief Health Information Officer, Geisinger

Any other comments? Pro, con, LOINC for what Pam said HL7. So, LOINC for human resources and HL7 for facilities, devices and other non human resources. Are we all comfortable with that?

Ok, we're not doing very well on time are we? Next slide #8. Any final thoughts on this? Jamie you want to lead the wrap up and lead us into public comment.

Jamie Ferguson, Chair, Vice President, Kaiser Permanente

The general method of having one or a minimum number of recommendations as the recommendations to essentially have a targets stated as our recommendations then modified by a separate transition section that can address the different specific needs for transition period. It seems to me that approach taken throughout and really throughout the document we will have to go back and potentially adjust other places where we may have said something for 2 and another thing for meaningful use 3. That general methodology I think sounds like it may be in fact more useful for measure developers and implementers. That also gives us a nice neat place to put specific recommendations about the needs for cost maps that need to be developed or published.

James Walker, Chief Health Information Officer, Geisinger

I think we're ready then for public comment.

Operator

No comment at this time.

James Walker, Chief Health Information Officer, Geisinger

Thank you all for your time and care with this.

Public Comment Received During the Meeting

1. Consider influenza immunization--without structure for both recording and exchange, any single organization would be hamstrung in the reporting of a quality measure related to this.