**MedMorph Consolidated Use Case Call 8/27/2020**

Goal today: Cancer UC DEs today, and HCS DEs if possible, and next steps.

Connectathon is happening next week – this meeting is canceled 9/10.

Covers WG logistics and schedule slides.

Recap of last week (sims/diffs among three UCs). Updates to In Scope, Out of Scope, Preconditions, Postconditions

Displays cancer DEs spreadsheet.

Goes over spreadsheet headers, and how NAACCR plays in.

Wendy covers differences from NAACCR and how mappings are included for such cases.

Wendy B. explains how address at diagnosis is derived.

Becky goes over identifier elements missing from USCDI, some will be proposed to USCDI, others not. Wendy: ID elements may not be required under NAACCR.

Cindy: Birth and Mortality will be requesting a birthplace.

Wendy: NPI only NAACCR element required. What do states think of others?

Nigar: anything states can get very useful.

Becky: what about physician?

Nigar: they look at it, basic info okay.

Wendy S: need name and NPI?

Nigar: physician name and NPI useful

Jeremy (CA): need physician info for follow-up, the more the better

Wendy B: could include for all provider roles. Any reason not to? Concerns?

Jeremy: no concerns.

Wendy S: no place in NAACCR XML for physician address (she thinks). Can you get the info from the database using NPI?

Nigar: nice to have both phys and facility NPI.

Steve (SE): challenge to get phys NPI, others around them often used? Which address is actually collected that is associated with phys?

WS: based on encounter data. Does that do it? Give most recent?

WB: extracted electronically, so whatever’s in there. More is better, so be expansive on first pass through. Use various FHIR profiles/USCDI to grab all data we can.

SE: could be specific about using provider NPI.

WB: provider have roles, need apropos NPI.

SE: doesn’t guarantee correct NPI will be used.

WB: will define clearly as we can, all we can do.

Brian: encounter resource will have individual’s NPI, not organization’s NPI. Up to people entering.

Brian: (12:36-12:38) provenance info.

Becky: (proceeds with other DEs)

Becky: EHR info in cancer UC.

Becky: encounter info use.

WB/WS: discussion of reason for visit, what falls under it, eg visit for depression due to cancer)

BG: Does cancer collect on comorbidities?

WS: Yes, but there are exclusions at the state and national level

BA/WB: primary diagnosis use?

WS: if multiple cancers/surgeries, want to know location (arm, leg, etc.). Need location coded up for each surgery. Have in CDA, would like to have in FHIR.

BA: classification of encounter, subject of enc., participants, roles. HCS needs primary provider and others involved.

WB: this is another way of getting to provider types noted above.

BA: encounter location NPI in cancer, not in HCS.

BG: yes, want it in HCS.

BA: maybe not a must support.

BA: starts into “Cancer Diagnosis Information” section

BA: DEs fall into two different buckets, be nice if they were all in one (problems).

WB: no use having it in narrative, need NLP there. Better to be structured, discrete.

WS: any reason to include pathology report narrative? Not useful.

BA: info in there that may not be available elsewhere.

Paul Wormeli: in CA moving to have everything structured. Hate to see narrative kept alive as part of things.

BA: wraps up. Next week canceled. 9/17 reconvene.

Note: nothing at all put in chat this week.