**Meeting Agenda/Notes**

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| **MEETING TITLE:**  MedMorph Project: Cancer Use Case Workgroup | | | | | **DATE SCHEDULED:**  **February 7, 2020** | | | | |
| **MEETING PURPOSE:**Improve Health outcomes for the Cancer Use Case Workgroups Vision, Scope, and Goals | | | | | **LOCATION:**  Skype | | | | |
| **PROGRAM/AREA:** Cancer Use Case Workgroup | | | | | **NOTE TAKER:** Becky Angeles | | | | |
| **FACILITATOR:** Wendy Blumenthal | | | | | **ONLINE FACILITATOR:** Jamie Parker | | | | |
| **SCHEDULED TIME** | | | | | **NEXT MEETING** | | | | |
|  | **Start**  1:00 PM | **Stop**  2:00 PM | **Total Hours**  1 hour |  |  | **Date**  TBA | **Time**  TBA | **Location**  TBA |  |

**Meeting Agenda**

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| **A** | **Introductions to Use Case Development Team** |
| **B** | **Use Case Methodology and Process** |
| **C** | **Working Session:**   * **Review Draft Use Case Sections:**    + **Description**   + **Problem Statement**   + **Use Case Goals**   + **In and Out of Scope** * **Discuss Draft Cancer User Story** |
| **D** | **Next Steps** |

**Meeting Summary**

The Cancer Use Case Workgroup met on January 17, 2019 for their second meeting. Participants discussed the importance of Cancer Surveillance and different methods to inform and enhance the Cancer Use Case vision, goals, and scope to improve health outcomes for cancer cases. This is an open discussion and are open to any suggestions or feedback.

Below are additional notes taken during the meeting, slides will be provided for reference as well.

**Key Meeting Notes**

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| **Introductions to Use Case Development Team** | Wendy Blumenthal introduced the Carradora team members Jamie Parker and Becky Angeles who will be leading the workgroup through the population of the use case template for cancer. |

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| **Use Case Methodology and Process** | Becky led the group through the sections of the use case – giving descriptions of what kind of content is found in each section. Jamie then took the group through the use case development timeline. |
| **Working Session: Review Use Case Sections** | * **Description**   + Wendy: We should generalize a bit to just say “Leverage existing FHIR IGs” (and include the mCode as examples)   + Paul Drawz - Univ of Minn: worried that we say we won’t replace existing methods that are working well. What if we do?     - Wendy: 75% of hopstials have cancer reporting and well-established methods in place. They have transmission methods and standards (doesn’t use EHR directly) which will not be replaced by this effort. Make the statement more straightforward “hospital registry reporting”.   + Bill Lober (via chat): I like the specific focus on “transmit cancer case information” - we can revisit that verb as we develop the use case, but I like the starting point of a narrow focus.   + Bill Lober (via chat): I also think we can say rather than “not replace” - that we plan to “develop methods that offer improved automation and efficiency in cancer case reporting” and not mention whether existing methods will continue or not. I can talk more specifically to Wendy/Becky about this once I have “a voice”! * **Problem Statement**   + Wendy: there is a lot of content here that has been pulled from starting content. Narrow this down to a few bullet points.   + Dave Dorr: 1st 2 of general challenges tie to goals. Will all the challenges on this slide be solved by the use case. Suggest getting rid of the physician reporting and other challenges that aren’t directly tied to the description or goals.   + Maria: For the higher levl goal of architecture – quality reporting where data is coming from other sources and building on that will be touched on other artifacts. * **Use Case Goals**   + Paul: if we aren’t going to provide information about missed cases and the incident data – this will be incomplete.   + Wendy: canacer surveillance is a multi-source system. Some state registries are already getting that information. This use case doesn’t focus on all the facets – just the ones that aren’t in place.   + Paul: If the purpose is to have data faster and the majority of the cases that are reported from a hospital data registry take 3 yrs (really it is only 6 months per Wendy) you have to wait 3 years for the details (its really 6 months) because were not including key information from hospital registries. 27:24 * **In Scope**   + No comments * **Out of Scope**   + No comments |
| **Working Session: Discuss Draft Cancer User Story** | Wendy: The first user story is a narrow focus. We may work on and include an additional user story as we go along.  Jamie: What triggers the report being sent? Diagnosis? Validation of the lab report? Lab report Data integrated in the clinical record with a cancer diagnosis?  Wendy: For the CCDA IG, we used the diagnosis code. EHR folks- is the problem list where the diagnosis code would live? Chief complaint? Reason for visit?  Ryan Mullins: Consider the encounter diagnosis and problem lists. Cautious of chief complaint. Reoccurrence indicator. If there is a cancer diagnosis made by a pathologist during an encoutnter are reported to CMS.  Brian Dixon: Cue in on the pathology report.  Wendy Scharber: What pathology labs are you talking about? Hospital or free standing? Ryan Mullins: It comes down to principle of someone performing functions (41:30)  Wendy B: A discussion point is to whether or not pathology results get discretely into the EHR (PDF attachment, not at all, etc). Is this a pre-condition that should be added to our use case?  Ryan: If we are going to limit to EHR systems – claims data used by CMS and can help provide identification.  Wendy B: There are certain cancers that don’t have pathology (bone marrow cancers) and they are under reported.  Ryan: We need to structure the logic (46:22)  Jamie: Can the reporting and patient notification happen at the same time (does one need to come before the other)?  Ryan: Don’t send a patient notification from a pathology report. The dr needs to discuss it will the patient first.  Wendy: If it is a confirmed diagnosis, can the system send the report before the patient is notified?  Ryan: Are there any potential negative implications? Problem list items – need a criteria that says a diagnoiss has been made by a licensed clinician. There should be a delay when it is from a pathology report.  Wendy S: When the diagnosis is made by a clinician – it is reported to the central registry and has a required timeline (varies by state systems and what the senders system set up). It can go before the patient is ntofied. Some batch them daily or weekly. Its been flexible.  Brian Dixon: That is a challenge, not every state does it the same and there are different timings. |
| **Resources** | * NPCR Website: <https://www.cdc.gov/cancer/npcr/index.htm> * NCI SEER Website: <https://seer.cancer.gov/> * NAACCR Website: <https://www.naaccr.org/> * [NAACCR Version 18 Data Standards and Data Dictionary](http://datadictionary.naaccr.org/) * [HL7 CDA® Release 2 Implementation Guide: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1, DSTU Release 1.1 – US Realm](https://www.hl7.org/implement/standards/product_brief.cfm?product_id=398) * [Pathology Laboratory Electronic Reporting Version 4.0](https://www.naaccr.org/wp-content/uploads/2016/11/Pathology-Laboratory-Electronic-Reporting-Version-4.0-April-2011.pdf)   Bill lober: Consider replacing “reason for visit” with “visit”  I think the area of triggering is pretty broad, and in the user story, I’d be a bit less specific than “reason for visit” - BUT - this is a critical area (triggering) for the use case, and I don’t mean to de-emphasize it. Just that it doesn’t need to be specified in the user story - and might be limited to do it there.  Bill Ober: My point is the same as Dr Mullins’ first point - a specific field (eg encounter Dx, reason for visit, etc.) is too limiting as a trigger?  Paul Drawz: No need to read, just a comment... It is true that some cancer diagnoses don't include pathology reports but I don't think it's necessarily more likely for blood and bone marrow cancers. Spouse is a hematopathologist - pretty sure she or a pathology colleague are involved in diagnosis of nearly all blood/bone marrow cancers at her institution.  Bill Lober: Our practice has to be consistent with legal authority - Wendy Shepard’s comment is very helpful. So the real issue is when is “diagnosis is made” triggered. Sounds like verification of path report  Batching is an artifact of the current practice, but if we build a faster pathway, that pathway should be used as soon as the legal requirement (clinician Dx) is triggered…. ?  See the comments - I said “wendy Shepard’s right!" |

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| **Next Steps** | * Weekly Workgroup Meeting   + Proposed times to start next week:     - Monday 2-3     - Thursday 4-5     - Friday 1-2 * Review and comment on Use Case Sections: Description, Problem Statement, Goals, In Scope, Out of Scope, User Story (User Stories)   + Email edits to becky.angeles@carradora.com |