**NBS HL7 Workgroup Meeting Call Notes**

**October 3 2017**

**Attendees:** Riki Merrick, Heather Wood, Rhonda West, Brendan Reilly, David Jones, Rebecca Goodwin, Joshua Miller, Careema Yusuf

**Agenda:**

* Update on the presentation:
	+ Went really well, Brendan had the flu, but folks still liked all the slides
	+ One of the providers was thinking to get away from having something that we have to still further constrain – but that only works when states do everything do the same way
	+ Writing queries would be better if all would have
	+ Difference in how some of the information is collected between states – example would be transfusion status
	+ Both sender and receiver have to conform to the standard – have the data producer create an Uber message and ignore the elements that we don’t need – issue with PH is that there are rules that some data are not allowed to be collected, so they don’t want to get data that they are not allowed to collect
	+ Even the standardization of the collection card has not been successful
	+ Perkin Elmer moving to new platform, so NOW GOOD TIME to define what they should collect
	+ HIT WG is doing that ☺
* Working with all stakeholders and create the common data model and then review the HL7 guides for needed updates = long term solution
	+ If the majority of states agree on certain elements, then we can tighten up to RE
	+ If we cannot get the programs to use the data the same way, maybe we can agree on how to message them always the same way – ensure that there is a means of translation between the different representations – ideally we standardize the way we collect information
* Update on LOI:
	+ Ballot reconciliation is completed – no more open issues – Riki will start editing and then there may be a few more questions – goal is end of October.
	+ Ordering Provider is still required – there should be a protocol or someone identified that can be filled in
	+ Need to look at LOI#112:
	+ The larger group did not want to use SPM-2.1 for the bloodspot card number – they propose to use SPM-31 as R element for NDBS, using the CX datatypes
	+ How to best transition for providers that are already sending OBX with the defined LOINC – would need to have the receiver flexible to allow both for a while for sure – and share migration strategy
	+ ONC is looking for stories that help illustrate the benefit of switching from existing interfaces
	+ Concern expressed about the date of collection – most hospitals are going to send orders from LIS, not the EHR-S; but the concern was about the workflow of when the order is placed vs when the message is sent
* Update on LRI:
	+ 15 open items – none for NDBS perspective
	+ Limited the number of O elements to the ones we had identified in the PID – the others are all O now.
	+ For grouping made no changes at this time
	+ LRI use for sending NDBS results – MI has 1 pilot hospital – working on ordering, still hung up on a few items: #1 issue are the NICU factors – having the single LOINC for multiple factors is a problem for them
	+ Have gotten them in touch with WI (Sam) – looking for 4 different things (NICU, special care setting, on Abx, meconium ileus – and send single “none” if all are declared as no (they could send them as individual nos) – Brendan will resend his responses – configure the system to require answers to each of these questions so that when they answer ‘No’ then that is what they can send. None answer was included in the LOINC answer list to cover the situation, because it is required; do we need to support ‘unknown’? We don’t really want to give them an out to get the info; if you require the answer that might have to happen – or set up as “check all that apply”, but then what would it mean if the box is not checked; so do we need to split this out into individual elements with the Y/N/U – this will make for more clicks, but could set up “none” button to auto-check all boxes to ‘No’
	+ Set up these calls for HL7 user group – need to figure out the frequency