|  |  |
| --- | --- |
| VA Logo | *Innovation 873 Telepathology UAT*  *Meeting Minutes* |

***Date****:* 26 June 2015

***LYNC****:* 855-767-1051

***Meeting Lead:*** Peter Bayer

***Time***: 2:00 PM – 4:00 PM EST

***Conference ID:*** 84514684

***Facilitator:*** Peter Bayer

***Scribe****:* Peter Bayer

**Invitees:**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name** | | **Last Name** | **Title** |
|  | Stuart | **Frank** | **Senior Developer** |
| x | Angela | **Barnes** | **Project Manager/ COR** |
| x | Larry | **Carlson** | **Innovator** |
| x | Stephen | **Chensue** | **Pathologist, SME** |
| x | Peter | **Bayer** | **Account Executive** |
| x | Nora | **Ratcliffe** | **Pathologist, SME** |
|  | Michael | **Icardi** | **Pathologist, SME** |
|  | Mark | **Gusack** | **Pathologist, SME** |
|  | Hon | **Pak** | **MD, FirstView Medical Information Officer** |
| x | Dee | **Csipo** | **Senior Engineer** |
| x | Csaba | **Titton** | **Senior Engineer** |
| x | Nihant | **Bondugula** | **Security Engineer** |
| x | Kalpana | **Reddy** | **Test Engineer** |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
|  | **Presenter: Frank, Stuart** |
| **Topic: Meeting Overview** | **Presenter: Frank, Stuart** |
| **Discussion:**  Stuart explained the UAT and what we would be showing in the demonstration. He began by running through the configurator explaining that it was not something the pathologists would likely ever use, but their IT support would; the point being that there is some flexibility in how the capability is set up to enable clinic/facility unique features.  Stuart asked Dr. Ratcliff to be the referring pathologist in the Nortern Indiana site, and Dr. Chensue to be the Consulting Pathologist on the Ann Arbor site.  Stuart first began by entering the Northern Indiana location which in this UAT is the referring site. Screens are “green screen”, not GUI. Demo utilized Mirth, which simulates Aperio re: HL7 message generation to/from external systems. Initial steps shown to accession relevant materials/lab results.  Q: Dr. Chensue asked if all accessions will default to requiring a consult. There was discussion on the use of filters/flags to indicate when a consult was needed, but that not all accession will require a consult.  Q: Dr. Chensue also asked if an accession can be flagged for consult after the accession has been entered.  Stuart first stated that a preferred way of filtering relevant HL7 messages is on the vendor side (as messages consume little space/time and this way the vendor have all messages upon some unexpected change or needs).  Stuartthen began to guide Dr. Ratcliffe through the initial steps on the referring side that ended with the initiation of a consult request. The detailed steps were accessioning (roll&scroll – by Stuart), viewing/reserving the case in the Worklist Manager, adding slide to the case (by Stuart using the Mirth simulator tool), viewing Health summary for the case, Editing the Report with focus on select fields (Gross Description and Clinical History) adding a Note (that is like a text message to aid the workflow) and finally requesting a Consult from Ann Arbor and unreserved the case.  Q: Dr. Chensue raised a question about standard accessioning practices, which he and Dr. Ratcliffe carried on with the outcome seeming to indicate that accessioning practices may be standardized at a given facility but not necessarily across facilities.  Dr. Chensue noted that all data entry has to be hands free, so there need to be voice command. Dr. Ratcliffe added that in “roll & scroll” in Vista there is no text formatting which can cause challenges.  Stuart stated that integration for dictation is initiated by contacting the vendor (VoiceBrook). Stuart then simulated “scan from slide” and asked Dr Ratcliffe to view the slides from the Worklist manager. After that Dr. Ratcliffe initiated the consult request. Stuart also created a new filter for cases “pending” which returns only the cases of consult requests from the referring site.  Q: Dr. Ratcliffe asked a question about verification of before a consult request is accepted—ie, can the referring/requesting pathologist reject or not accept the consult request into the master record?  A: Only the Consulting pathologist has the ability to decline a pending consult request.  Next, Dr. Chensue was given control to invoke the application being logged in to the Ann Arbor (consulting) site. He reserved the pending case, viewed the Slide for it and, entering the Edit Repot menu, added a Supplementary Report, completed it, then viewed the report as is.  Dr. Chensue and Dr. Ratcliffe expressed that they did not want to send/receive “view alerts” for any actions prior to a final verified (Main) report. This would result into to many messages with limited meaning that would overwhelm the doctors.  Then Dr. Ratcliffe was given control again on the referral site. Sho viewd the Supplementary Report, than the completed the report templetes and finally virified the Main report.  Q: Dr. Ratcliffe asked what happens if you verify a supplemental report but not the main one?  A: The case is incomplete. The proper (required) order of steps: Verify the Supplementary Report(s) first, then complete and verify the Main report.  Dr. Chensue noted that the MID SP 15 92 report as presented was not compliant as it needs both sites (referring and consulting) to be identified and the CLEA # to appear in the report itself. Stuart requested some sample reports (anonymized) to ensure we capture and include all necessary fields.  Stuart demonstrated that CPRS in Vista shows the record. Dr. Chensue stated that this is where he looks for it by default; Dr. Ratcliffe usually looks for it in the “Labs” view or module, which showed the same report/record.  Discussion around coding the study, which is how doctors get credit/effort on consults is tracked. This capability will be added if we get additional funds as has been discussed with Larry and Angela. It will require a discussion and identification of the business rules/practices for coding.  Stuart asked if VA used SNOMED or IDT codes. Dr. Ratcliffe stated that Vista does allow them but not as a standard practice; CPT codes used widely. Dr. Chensue stated that Telepathology requires CPT codes. Stuart asked which CPT codes they usually enter in Telepathology. Dr. Chensue indicated that they only use two: 88321 (micro slide) and 88325 (full chart review)—these aren’t Telepathology specific; TP specific codes haven’t been defined yet. These two codes are entered as part of the initial encounter.  At this point, the intended functionality was demonstrated and the UAT came to a close. | |
| **Topic: Project Status/Simulation** | **Presenter: Frank, Stuart** |
| **Simulation:**   * Full UAT testing of product | |

**Status of Actions from previous meetings.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Action Item ID No.** | **Assigned Date** | **Description** | **Assigned To** | **Due Date / Revisit Date** | **Comments** |
| **1** | **3/27/15** | **Find a Workload SME to discuss Telepathology processes with Stuart.** | **Dr. Ratcliffe** | **N/A** | **Complete** |
| **2** | **3/27/15** | **Contact VA headquarters to help determine which hospitals use Telepathology capability currently (they could be ideal candidate as pilot sites).** | **Dr. Ratcliffe** | **N/A** | **N/A** |
| **3** | **3/27/15** | **Provide input to Angela to answer questions from March 26 email regarding list of COR questions.** | **Dr. Ratcliffe** | **N/A** | **Complete** |
| **4** | **3/27/15** | **Contact Leica/Aperio POC in order to enable discussion with VitelNet for Telepathology use of vendor products.** | **Angela/ Larry** | **N/A** | **Complete** |

**Additional Notes/Comments:**

* A follow-on UAT will be scheduled in the near future to provide the same information to Drs. Icardi and Gusack. This next meeting will follow a similar format to this meeting.