NATIONAL QUALITY FORUM

Moderator: Value Set Harmonization
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OPERATOR: This is conference #:   60416313.

Jason Goldwater: Good afternoon everybody and thank you for joining the Technical Expert Panel Call Value Set Harmonization call. I'm Jason Goldwater, the senior director on this project. It's good to see you all or see all of you virtually and thank you for taking some timeout to talk with us this afternoon.

The purpose of this call is to go over what we would like to do for the third and final pilot test for this project. We are greatly appreciative of all of you participating in the first two pilot tests with respect to medications and diagnosis and particularly with the RxNorm and the SNOMED codes. Those were very helpful and really helps set a nice foundation for the report that we will be writing towards the end of the year.

We're going to do something a little bit different this particular time around, which is we're going to describe what we would like all of you to do and make sure that that is clear and that you have a good understand of what we would like to get accomplished in the next couple of weeks and then we will be sending you the materials for you to go ahead and complete the pilot desk by Monday close of business. But we thought we would take the time today to just describe what it is that we're doing because it's going to be a little different than the worksheets that you have gotten from the past two pilot tests.

So we're going to start off as always with a welcome and roll call and what we're going to be doing with the third pilot test is encounters and particularly how we define value sets for encounters, exploring the issues and proposing solutions. We'll open the floor for discussion and question and then we'll talk about next steps.

Next slide. So I'm going to turn it over to Kathy Streeter, our senior project manager for the roll call. Kathy.

Kathy Streeter: Thanks, Jason. Hi, everyone. I'll be taking a quick roll call who has joined today's call. Do we have (James Case) on the line? (Vin Carmansky)?

(Vin Carmansky): I'm here.

Kathy Streeter: (Hendra Hanley)? (Rachelle House)? (Katherine Ivory)?

(Katherine Ivory): I'm here.

Kathy Streeter: (Jason Jones)?

(Jason Jones): Here.

Kathy Streeter: (Russell Letwitch)? (Katherine Lesch)? (Caroline Maycomer)? (Priscilla Mark Wilson)? (Nick Madison)?

(Nick Madison): I'm here.

Kathy Streeter: (Debra Seeter)?

(Debra Seeter): I'm here.

Kathy Streeter: You know, (Shelly's) not able to join us. (Alison Weather)?

(Alison Weather): I'm here. Unfortunately, I will have to drop off shortly as I'm jeering another meeting in my institution.

Kathy Streeter: OK. Thanks for joining. Anyone else joined but I didn't call?

(James Case): Yes, this is (Jim Case). Put me in the wrong call, so I just joined.

Kathy Streeter: Oh, great. Hi. OK.

Jason Goldwater: All right. So what we're going to do is to talk about the parameters around the third pilot test which is to talk about harmonizing value sets that are associated with the encounters. So what we want to do in this slide presentation, and this is will shorter than the ones we've had in the past because again, all we're looking to do is sort of just describe what we would like you all to do for the pilot test, is we want to define what an encounter value set is which is very different from a medication or a diagnosis one. How is encounter value sets are used in measure, the common problems that are occurring in encounter value sets and the potential solution which is taking an extensional value sets or basically a list of enumerated codes and creating an intentional value set which has more embedded logic and is really used as a rule and how we move from extensional to intentional and thinking and hoping that that might serve as a basis for rectifying some of these issues.

Next slide. So value sets that are associated with encounters. So encounter value sets are almost always defined in two ways. The first is they're defined by the current procedural terminology which is maintained by the American Medical Associates and most of those codes are in encounter value sets for groupers that also contains CPT codes as well as SNOMEDs at a richer vocabulary to what is going on during the course of a clinical encounter. The CPT codes are used so providently because encounters are something that you're paid for. So the CPT is used really primarily as a billing purpose.

Encounters are graded by a level of service on – in a scale of one to five and in that scale, it's defined by the type of patient, the complexity of the problem and the time spent with patient. It's also categorized by patient status, which is, is it an in-patient visit, in which case that would include observations as well as emergency department visit. Is it outpatient through an eligible practitioner, which would include preventative care follow up, specific specialist, behavioral health and urgent care. And actually, clinical encounters can now also include Telehealth and/or encounters in the home. And encounters, as most of you know, because I know a lot of you have dealt with going over the gears. Encounters were associated with (PAMA), the CMS

bundles encounters in different locations to determine the type of payment reimbursement.

Next slide. So for example, here is – and I won't get into all of this, but here is an office visit encounter value set. NCQA is the steward and there is the associated identifier. I mean, you can see there are three distinct codes, all of which as CPT. The first one is the evaluation management of a new patient that has three components, a problem focused history, a problem focused examination, straightforward medical decision making, the presenting problems are self-limited and minor and typically, 10 minutes are spent face-to-face with the patient and her family.

There's also another code that goes with this, which is also for a new patient but this one is an expanded problem focus history, an expanded examination which also includes straightforward medical decision making. The presenting problems are low to moderate severity and typically 20 minutes are spent face-to-face with the patient and her family.

The third code in this particular example is also a new patient but involves a detail history and a detail examination and decision making of low complexity. The presenting problems have a moderate severity and there's typically 30 minutes spent face-to-face with the patient and her family.

Now, what this is just simply an enumerated list of codes. So it basically goes into a value set and a clinical measure as just a split. There is no, at this point, somewhat embedded logic as to what encounter would be appropriate for the particular visit when that encounter is actually taking place.

Next slide, please. So what we are looking to do, what we are trying to do is to create an intentional value set for the clinical encounter. As it is now, they are – since they are essentially extensional lists which are just an enumerated list of codes and they're static, they cannot be dynamically updated, so static list of codes in the value set that's associated with the measure.

An intentional value set is the developed as a rule that is algorithmically defined. In other words, there is a logic embedded into the set itself.

So for one example, having a value set represent all of the beta-blocker drugs that are used for blood pressure control. As the quality measure is created for blood pressure, if this was an intentional value set, it would be included and would include the appropriate medications based on the definition of measure. It would also use the appropriate value space on the patient's condition.

So if there is a quality measure that is focused around blood pressure control and the patient presents in a clinical encounter and the doc – the practicing physician monitors blood control, blood pressure and prescribes medication as a result, the patient, based on the information in the H.R. is included in the denominator because they are a patient that is presenting with a blood pressure problem and a numerator of the measure from the value set within the intentionally realized and that it would put out the proper medication and the encounter based on what the patient was presenting with, rather than it just be this group of list of codes that could be – anyone of them could be picked out.

So an intentional value set can also be dynamically updated. Which means, as there are changes to coding, the value set is updated dynamically, it is continuously updated, it is not static, it is always living. So those codes can always be updated. An extensional value set is always static. So you can't update that. You essentially have to create the value set which is what's been happening.

Next slide.

(James Case):   Jason, this is (Jim Case). Can I interrupt for a second?

Jason Goldwater: You may.

(James Case):   And just ask at what point you might want questions?

Jason Goldwater: We'll get to a discussion point, (Jim), but you can ask one now if you'd like.

(James Case):   No, I'd let you finish and then we can talk about it.

Jason Goldwater: OK. So what are the current challenges with extensional value sets for encounters? There is a lack of standardization for measure to measure, value sets, this would reflect the efforts of providers who provide the care that transitions. So like, an endocrinologist that reports on statin and blood pressure, that is difficult to do right now because there's no standardized way of doing that. And there's a need to define value sets that are position oriented that targets both Medicare and Medicaid population that looks at such things as preventative care and accurately describes the level of service, shows the intervention for immediate wellbeing, captures urgent care and captures follow up care.

Next slide. So moving from extensional to intentional value sets. So the task of the third pilot test is to create an intentional value set associated with encounters in the best way possible. So to try to create a defined value set that identifies an eligible outpatient provider, these office based, a homecare provider or even one that is Telehealth, to focus the encounter around a single topic and to make the value set procedure base. So either it's focused on prevention or just focused on an immediate intervention – and an intervention for immediate wellbeing.

So again, what the idea here is, is to have the test to the best of your ability, try to create an intentional value set around a single topic and we'll tell you what that topic is on Monday, it identifies the appropriate provider when the encounter occurs and it talks about the procedure that was being performed, whether it's preventative or whether it's intervention for immediate wellbeing. Because right now that is difficult to ascertain and delineate because of the extensional value sets that exist.

Next slide. So what do we want you to try to do? So by October 26th, we're going to send you the follow up, a clinical quality measure topic and we're still working with ONC on what topic they would like that to be. What's the goal of that overall measure is supposed to be? The current extensional value sets that are associated with that measure. And then, what we would like you to do is to take those value sets that are extensional, understand the topic that we are focused on and what the goal of that measure is and see if you can create an intentional value set that identifies the provider and that identifies

whether it is – the encounter is for preventative care or for an immediate intervention.

So to the best of your ability, please create an intentional value set that best represents the measure. I want to stress that the object here is not to be perfect and not to think that you have to be perfect. What we're really trying to look for is, how would you go about doing it? Being inside on how you think this could or should be done, if it can be done at all. If you think this is an impossible task and that's what you need to see. But what we would like to see is, how you would go about doing this in a way that might be replicate?

Next slide. So when you're working on this pilot test, we like you to focus on the following questions, what was the process you used to create the intentional value set, how could this process potentially be replicated and used for other extensional value sets and if you are able, can you describe what you felt the strengths worthy approach and what you think might be some deficient? That's really all we want to address.

Again, it doesn't have to be perfect, it doesn't have to be something that could immediately be published in the (VSAC) because it won't be. But we just want you to go about thinking about this and then tell us how you would go about doing this, why you think it would work, what you think it's good at doing, what you think it might not be good at doing. And that's the information that we'll take to the value set committee when we meet with them in person on the TEP and then we'll tell you the results of those conversations shortly thereafter.

Next slide. OK. So (Jim), this is the point where I'm happy to try to address questions.

(James Case):   OK. A couple of (inaudible) that just – so that people can get an idea of the level of the challenge that you've got – that you're putting in front of us here. There are a number of prerequisites that a code system has to conform to in order to be able to create intentional value sets to begin with. One is that it have a computational model behind it that can actually be used in the algorithm that you're defining.

The second thing is that it would need to have version control. In other words, you know what version of the code system you're using.

Jason Goldwater: Right.

(James Case): And then, the third thing is, there has to be something called concept permanence which means that the same code cannot be reused over multiple versions to mean different things. There are very few code systems out there that conform to those three things. And so, creating an intentional value set – the only one that comes to mind right now that does that comprehensively is SNOMED.

Jason Goldwater: Right.

(James Case): And so, if you wanted to create an intentional value set, you would have to restrict it only to the code systems that adhere to those – to that level of sophistication of the underlying model. Primary because there's nothing to base the algorithm on, if you don't have a model in the terminology.

Jason Goldwater: Correct. Right. So I think what – and so sort following the same methodology that I think we've employed in the past pilot tests are, as you take these CPT codes which granted (them) are not designed for – you know, to be dynamic nor to be put as part of an algorithmic computation because they're used for payment reimbursement clearly. So just try to map the CPT and the – you know, what the encounter is about and what the purpose of the encounter is and to see if you could then map to the SNOMED codes that would potentially define that measure in a way that it becomes intentional.

So moving – or to the best of your ability, transitioning away from CPT into SNOMED codes that would then be used in a clinical encounter and realizing, of course, that that is challenging because – and I'm not pretending for a moment, this is not going to be fraught with potential challenges. But ONC asked us to take a look at this because this has been a recurring problem that measure developers and those that are using measures have walked into. And they are trying to resolve it in such a way that they can create some sort of

standardized intentional way that would hopefully reduce the amount of variation and not become so static. But agreed that really the only way of doing that in a way that would be meaningful is to – probably map the CPT to SNOMED that needs the SNOMED codes.

(James Case): So another resource that might be of use then and that is, there's a new document that was just recently published by the IHTSDO that owned SNOMED on something called an expression constraint language which is essentially a language to create intentional value sets …

Jason Goldwater: OK.

(Jim Case): … for SNOMED. So I encourage people to take a look at that.

Jason Goldwater: Sure. And actually, (Jim), if we can get a hold of that, we'll send that out to all of you on Monday when we send everything else. Thank you for bringing – for mentioning that. I had no idea that was out there.

Are there any other questions? And again, if you have questions as you're doing this, you're welcome to ask us. And if we don't have the answer, we can certainly talk to ONC quickly to get the answer. Any questions?

OK. Next slide, Kathy. So we'll provide the worksheets, the supporting materials to be e-mailed by Monday. We will probably ask for everything back by the 5th of November which is two weeks from this Friday and if you need – if you feel like you're going to need more time, then just let us know. But if you get it back to us by the 5th and we have time to sort of consolidate your comments, talk about your approaches and get that ready for presentation to the value sets. But we will discuss that with them during the in-person meeting on November 10th and then we'll discuss the result of those discussions with all of you at a time shortly thereafter and we'll also let you know how we're going to include that in the report.

So I don't want, you know, to feel like you're doing this and then you don't hear what the results of it are. It's just the way this is timed by the time we get your material back, we'll have the in-person meeting, we'll talk about it with them and then we'll have a longer meeting with all of you to discuss the

results and a proposed halfway forward because I think we'd like to get your input to that as well.

Now, I believe that is it, if there are no further questions. Again, our project contact info is the same and as our project team e-mail. We will send you all of the materials on Monday. If you have any questions as we move forward, please do not hesitate to ask any of us. We will help you as to the best of our ability. We will get a hold of the document (Jim) just referenced to make sure that we are able to pass that out to all of you as well and we look forward to what you're going to come up with. And again, it cannot be stated enough that we are very grateful and thankful of you for taking the time to do this. It's a really important work. I know it would be very meaningful to ONC and they're incredibly pleased and should be mentioned with the work that you all have done so far, as are we. This really helped us a tremendous amount. We're very thankful to all of you for your efforts. I know how busy everybody is, so it is very appreciated.

So with that in mind, we will conclude the call, unless anybody has any last minute questions they'd like to ask and Kathy, if there's any public comment, now would probably be the time to listen to them.

Kathy Streeter: Operator, do you mind opening the lines to see if we have public comment?

Operator: All lines are open.

Kathy Streeter: Thank you.

Jason Goldwater: Any public comment. OK. Well, I wish everybody a great weekend. And so, we will not be talking to you. A terrific Halloween if you are engaged in such activity and we will talk to you all very shortly. Thank you all very much and we look forward to (hearing).

Kathy Streeter: Thank you.

Jason Goldwater: Thank you.

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