NATIONAL QUALITY FORUM

Moderator: Katie Streeter
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Operator: This is Conference #28356273

Katie Streeter: Hello. Good afternoon, everybody.

This is Katie Streeter at NQF. And I'd like to welcome everyone to the Value Set Harmonization Technical Expert Panel orientation.

Today, we'll be providing you with a project overview. We'll be talking about the role of the technical expert panel, as well as getting into some discussion of the preliminary analysis that staff has started to work on.

I'd like to welcome and introduce our project team. I'm in the room here with Jason Goldwater, who is senior director; (Sharon Hibay), senior director; and (Anne Phillips), who is project analyst.

At this time, I'd like to break and take a quick roll call to see who is with us on the call today. Do we have (James Case) on the line?

(Lynn Koromanski)?(Kendra Handley)?

(Kendra Handley): I am here.

Katie Streeter: (Rachel Howe)?

(Rachel Howe): I'm here.

Katie Streeter: (Katherine Ivory)?

(Jason Jones)?

(Jason Jones): Yes, I'm here.

Katie Streeter: (Russell Leftwich)?

(Russell Leftwich): I am here.

Katie Streeter: (Katherine Less)?

(Katherine Less): Here.

Katie Streeter: (Carolyn Macomber)?

(Nick Madison)?

(Nick Madison): Here.

Katie Streeter: (Kristin McNuff)?

(Deborah Vitah)?

(Deborah Vitah): I'm here.

Katie Streeter: (Shelley Spiro)?

(Shelley Spiro): It's (Spiro), and I'm here.

Katie Streeter: (Allison Westhers)?

(Allison Weathers): I'm here.

Katie Streeter: Thank you.

Do we have anyone else with us that I didn't call?

(Allison Teel): Yes, this is (Allison Teel). I am filling in for (Priscilla Marx Wilson) today. Unfortunately, she could not attend.

Katie Streeter: Great. Thank you.

And I also see that (Katherine Ivory) has joined us.

OK, before we proceed, I'd like to let everyone know that today's call is open to the public. We will be also recording the call. Towards the end of the meeting, we will open the lines up for any public comments.

So just a quick overview on NQF and our mission. NQF is a private nonprofit voluntary consensus standard-setting organization. We consider ourselves to be a neutral convener. And we operate under a three-part mission to improve the quality of American healthcare. By building consensus, our national priorities and goals for performance improvement and working in partnerships in order to achieve them; endorsing national standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs.

We are made up of – our membership is broken into eight councils. The councils include consumer health plans, health professionals, provider organizations, public and community health agencies, purchasers, quality measurement research and improvements, supplier and industries.

And now I'd like to turn it over to Jason who will speak to the project overview.

Jason Goldwater: Thank you, and good afternoon to all of you.

I wanted to start off by giving a brief background on this project and then going into the work that has been done to date, as well as the work we are hoping to do in the next few months. In 2012, the National Library of Medicine, along with ONC and CMS, launched what is known as the Value Set Authority Center, or VSAC for short. The VSAC provides downloadable access to all official versions of vocabulary value sets that are contained in the (minithial) stage two; the measure specifications, which are also known as the 2014 clinical quality measures. They will also have the vocabulary value sets for meaningful use stage three measures once those are released.

Through the VSAC, the (MLM) has been charged with what is known as (curation), ensuring that the value (inaudible) codes are not incorrect, are not mal-informed, do not contain code system or code mismatches, and do not contain code or description mismatches.

However, to enable these to be used efficiently to build and maintain effective electronic clinical quality measures, (curation) alone is not enough. There is also a need to validate the meaning of codes, to understand the intent of the measures, and to assess multiple competing value sets that are addressing the same intended purpose in order to harmonize them.

The value sets in the VSAC describe the specific populations in clinical action, both included and excluded in order to properly calculate each of the clinical quality measures for eligible professionals and eligible hospitals in the 2014 stage two rule. And there is a diagram – I'm not sure how easy that might be able to read on your screen, but it does give a basic description of what a value set is. I will let you go ahead and take a look at that and if you have any questions.

My feeling is most of you have probably seen this before and are – understand what a value set is. But if there's something specific you'd like to know, you could certainly ask after this presentation or ask us later.

Value sets have a very specific life cycle, much like electronic clinical quality measures do. There is a conceptualization of what that value set should look like in order to map to the clinical intent of the measure. The measure author generally creates the new value set, which is draft. They submit another value set for the approval of the steward or the one that will oversee the measure.

The steward can either reject that value set, in which case the author then has to redraft it. Or the steward may approve. If it's an approved value set, the steward submits to publish within the VSAC at a desired date. The VSAC publishes the value set and value set versions are updated as codes update, and as the expansion profiles are defined.

So, they are not static. They are continually evolving, which is sometimes part of why we're having a harmonization discussion.

NQF, through the course of this project, is defining harmonization as the process by which unnecessary or unjustifiable variants will be eliminated from common value sets in these clinical quality measures by the reconciliation, integration of competing and/or overlapping value sets. Under the guidance of a value set committee, which is the other group that is associated with this project, we will develop and pilot test a value set harmonization and approval process.

In addition, the harmonized value sets will provide a basis of gap analysis and for examination of face validity of a value set. And hopefully at the end, it will also offer guidance on how the approved value set should be integrated into the endorsement process the NQF uses for clinical quality measures, particularly electronic ones.

The project in the next few months is looking to address the following issues:

What are the harmonization criteria for value sets used in electronic clinical quality measure development? And when is harmonization applicable? Will measure developers be mandated to demonstrate they have actively utilized VSAC harmonized value sets? And what components of this process apply to the review and approval of newly submitted value sets? And how should that process be structured?

We also want to know what are the role of value set authors and stewards in responding to recommendations for changes or additions to value sets. Will harmonization be mandated if they are unwilling or unable to make the suggested changes? How are the recommendations for these additions or changes integrated into the existing VSAC catalog? How does this integrate with our measure endorsement process? And how should developers anticipate the impact on measure development if value set approval and harmonization is an expected precondition?

The project timeline – some of this is still a little bit fluid. We had an idea of when we wanted to have the project milestones established, but due to some of the discussions within our value set committee and their desire for us to use

2015 stage three measures, or stage two measures, which might resolve some of the issues we've already discovered, this is a little bit in flux.

So we will look to try to get this a little bit more determined once we have an idea of when these measures are going to be published. And then, of course, we'll inform you immediately.

The deliverable for this project is a draft process or processes; a harmonization process for resolving missing, duplicate, competing or otherwise problematic value sets; the ground rules on the use of these approved harmonized value sets developed measures; and then the policies and procedures for coordinating this harmonization work with the National Library of Medicine.

We also want to do an evaluation of the value set harmonization testing, which is what we're going to use you for. Initially, we proposed doing five separate measures between May and October. That might still be the case, but we are actually looking now to potentially reduce that from five to three in order to give us more time to get in depth with a particular measure and value set, and some measures with a meaningful use, as you may know, have a very large number of value sets, which will require some extensive analysis on our part and a lot of evaluation activity on yours.

So we want to make sure that we're doing the in-depth job necessary to meet both the goals and objectives of this project, as well as crafting out deliverables that are actionable once this project is complete.

We want a final process. Again, this is somewhat a bit of a fluid deadline, but we will have a harmonization process, the ground rules and the policy and procedures. We look to have a draft project report sometime toward the end of the year. Per NQF policy, there will be public comment on that report. And we do look to have a final project report delivered to ONC and CMS and NLM in the spring of next year.

So, that leaves to of course the question all of you want to know at the moment, which is: Why are you here? Why are you on the phone? Why did we choose you? And what your role is. So hopefully, we're going to be clear.

What we're looking for you to do is to take the proposed process and methodology outlined by both ONC and the value set committee; perform analysis; see what's working and what is not; suggest resolution; and provide feedback from the process that include resolving definitional issues around the meaning of value sets; and the codes required to articulate that meaning; adjudicating the most complicated and judgment-dependent variances; and then probably most importantly, assisting NQF in the development of an interim process, again to create actionable policy that we can then leverage once this project is complete.

This is not to say we are starting from nothing. This is clearly something that we have been working on already since the project started earlier this year, in order to get an idea and somewhat of a handle on what exactly it is we would be dealing with and what exactly we were going to need from you. So we did see work analysis in the early part of spring, late winter. And there were some components of this that we used so we had an established framework.

The first is we used what is known as the (Wynenberg) (Bodenryder) analysis; (Olivier) (Bodenryder) is a informaticist within NLM, a highly touted informaticist. And he wrote a paper, along with Dr. (Wynenberg) that looked for the assessment for completeness and correctness of value sets and looked at ways of eliminating redundancies. And NLM has been using that analysis as sort of the foundation for harmonization.

So, following what they did, rather than reinventing the wheel, when we did our pre-work analysis, we used the same methodology.

For measure reporting, we reviewed the codes in sub-value sets in the same topic measures that are frequently reported to CMS. So, what we asked for was the most frequently reported eligible professional and eligible hospital measures in stage two of meaningful use.

When we got those, we then looked at the parent value sets and their object identification, and then went into the sub-value sets within each one of those and looked for those that had overlap. Some of the topic areas that we covered were depression, diabetes, stroke, VTE, and AMI.

We did a manual comparison, which I would not recommend doing, in which we looked at the codes and the content and the same topic measures. Those that we saw were overlapping or somewhat redundant, we highlighted. And then we used a (jacard) index, and that is a statistical method that compares the similarity and diversity of two sub-value sets. For those of you that may not be familiar with this, it's very similar to straightforward correlation analysis in that it provides a number that shows the degree of harmonization or overlap or redundancy between two competing terms, in this case two competing value sets.

So what did we find when we did this analysis? So, the depression measure is where we found the most degrees of redundancies and possible overlap, using the (jacard) index. The threshold score was.49. So anything that was.49 or above, we highlighted. And as you can see here, I won't go into every row because you're free to look at this. And again, if you have questions, you can ask at the end of the discussion or, of course, ask us later.

But we did find some similarities. Now, that does not mean that this overlap is not needed. In some cases, there are distinct differences. But in some cases, there are also some similarities. So for example, a depression diagnosis and then major depression, including remission; depression diagnosis; major depressive disorder that is (enacted); depression screening denominator encounter code; and then the BMI encounter code set; bipolar diagnosis; (Haverhill) health condition involving bipolar disorder; major depressive disorder that is active; major depression including remission. And then the last one, where there's bipolar disorder and bipolar diagnosis. There seems to be some considerable overlap between those.

And then we have to really factor in whether those need to be harmonized into a singular term, or whether or not those are things that are distinctively different and need to remain as is.

We also found other depression ones using (snow-med). One of the other methodologies that's worth noting here is that as you are all aware, there are a lot of terminologies that can be used within the construction of clinical quality

measures. And there are those that have been dictated by HHS to use. So (snow-med) for problems in diagnoses; ICD also for diagnoses; (RX-norm) for medications, and so forth.

For this pre-work analysis, we were told not to use the ICDs, to only focus on (snow-med), (RX-norm) for medication, (Loink) for lab, CPT for out-patient. Most of where we found the overlap almost was exclusive to snow-med codes, although we did find significant similarities between the snow-med and the ICD, although we did not delver into the analysis as that was not required at this point in time.

You can also see through this that we have terms like major depression, melancholic type, recurrent major depressive disorder with melancholic features, major depressive disorder, recurrent major depression, (totometry) testing or high-frequency (totometry).

Again, significant overlaps as the (Jacard) was indicating. Whether those are needed overlaps because they are distinctive terms, or whether they need to be harmonized is somewhat of what we're looking for you to do and tell us.

With the hospital measures, we looked again at stroke, VTE, and then we also did some work on the ATI. And rather, since these have a large number of value sets, we didn't do the sort of specific line-by-line sub-value analysis that was presented above in the depression measures. We basically looked for some overlaps manually and just looked at those in association with the measures themselves.

So here are the CMS measures that we were looking at. We looked at value sets associated with these measures, so you can see there was one parent value set, medical reason; another value of membership; another value set associated with medical contra-indication. These are the value assets that were associated with the following CMS measures. And they were entirely identical. There were no unique codes. They were a one-on-one match. And of course, interestingly enough, the joint commission was the steward on both of these.

We looked at five other value set codes, really looking at anti-coagulant therapy, (extensional) uses of aspirin, and injectable factor prophylaxis. Three, four of these were the joint commission. One of them was Lantana:

a small business consulting group, and then that led to after we really did the comparison – some specific questions is anti-coagulant therapy complete, cannot be harmonized with (terence feral) I can never pronounce this, (parentral) anti-coagulants. Anti-thrombitic therapy is missing amid the aspirin products that are found in aspirin, and the injectable factor is missing the same type drugs found in the anti-coagulant example.

We also found that there was a large list of medications within a value set for aspirin that were completely missing from anti-thrombitic therapy. As you can see in that description, there are code sets that were either some cases overlapping, and in some cases completely and utterly excluded.

We looked in hospital measures as again five specific value sets, looking at medications for VTE and AMI for statins, anti-thrombitics, anti-coagulants, warfarin, and heprin, again, joint commission was the steward for all of these. Some of the issues that were found, statin-specific medication names but no dosages, anti-thrombitic specific was duplicative with anti-thrombitic therapy, but dosage (imprenation) was not included in the specific value set. Anti-thrombitic specific and anti-coagulant specific were almost entirely duplicative of a very high card index for, warfarin only had no dosage information and the heprin prophylaxis was using the same ingredient drugs.

So again, do harmonize to make this more complete?

So I guess before we begin the discussion, I do want to talk about some of the results of what took place when we met with our value set committee, approximately two weeks ago. We presented much of the same information to them, and had an extensive all-day discussion with what those results were, what the issues surrounding value sets were, and to try to develop a methodology on how exactly we could pilot test a harmonization process.

Without getting into all of the details, because we will pass that information on to you, here's what was concluded.

Clearly, everyone recognizes that this is a problem. The depth of the problem is still not truly known. THere is obviously a need, a significant need to find some methodology of harmonizing these sort of disparate value sets that are either overlapping completely, or somewhat overlapping and might mean the same thing, where there's a need to then just have one single value set that is defined for a particular measure.

They also agree that this is a very complicated task, which I'm sure you would probably agree with, and as such, we need to make sure that we are doing the things that are necessary to offer a potential strategy for harmonization in a way that can be accomplished during the timeframe of this project.

So what was concluded is again, we may potentially be looking at only three measures, and rather than inventing anything new, we would use the measures that we have already now analyzed. So, we will be using depression for one, for sure, and that would be all of the measures associated with depression (immediate) we use stage two.

And then we are waiting to see if we are going to do either VTE, whether we're going to do stroke, or whether we're going to do AMI. We're still waiting to make that decision. Once we narrow it down to three measures, instead of focusing on all of the potential value sets that go into a measure, which would include diagnosis, labcoats, medication, outpatient, and possibly others, that we would take two of those measures, more than likely the hospital ones, and we would focus exclusively on medications only.

And we would be looking for ways of harmonizing the medication within those measures. And the way we would start this process is that NQF would call up the creators of these value sets to ensure that we had a clear understanding of what the intent was and why these value sets were created or duplicated. And once we had that, we would then come to you and say this is the intent of what these value sets were, and then for you to use Rx Norm, which is the standard terminology that HHS is requiring for medications in ECQMs, and look at classes of drugs and map or associate the value sets for medications that are already existing with the classes of drugs that are similar in Rx norms and go to what we would call an intentional value set measure.

So, it would be what – what – once we tell you what the intent of these value sets were, can you find classes of drugs that match up with the medications that are already listed, in which those medications can then be harmonized into these classes, and we're understanding the intent of those value sets and its relationship to the measure.

For depression, we're not going to do medications. We're actually going to use encounters. So, most of what we showed you did not have to deal with medications: they had to deal with the clinical encounter when someone presents with depression.

So, we want you then and not necessarily using, because there really isn't a prescribed terminology that is associated with encounters. So, we want your ideas on what reference terminology would be good here in order to take, again, the intent of these value sets and what terminology do you think you could harmonize some of these concepts in, whether it is continued to be (snowmed), and you just think the (snowmed) terms need to be consolidated into a single value set. Whether you believe ICD is better here. Whether you think CPT might be better.

We're not going to prescribe to you what you should be using. We're only going to do that for medications, because that's what HHS requires, but we do want you to give your opinions on what you think we need to use for encounters, and how you would harmonize those depression encounters using that reference set that you're choosing.

And when we have that discussion, I would imagine that will be the third value set that we do, because that will be the most challenging of the three that we look to have a fairly lengthy discussion with all of you about why you choose this terminology, why you think they're the best, and what harmonization activities you found when you were engaging in reconciling these overlaps, and what recommendations you would have for HHS.

When we convene the value set committee again in November, we'll go over all of these results. We'll get their feedback and commentary. We will then

relay that to you, and then we'll keep you posted as we're deliberating and creating a final report.

So, that is our spiel on the project, so I would – hopefully, I have not caused you to run away in fear over the scope of the project. We are very happy that you all have agreed to participate. We're obviously very well aware of your expertise and qualifications in this are, which is why you are on this panel. And again, once we have a better establishment of time-frames, because again, it's belief that the 2015 version of the stage two measures may have resolved some of these issues that we've found, so we want to wait until those come out to see if that does happen, and if it does, some of them will resolve. It makes the job easier. Rather than (inaudible) 2014, which could be a little bit time consuming.

So, when we have a more reestablished time frame, we'll let you know.

At this point, I want to stop talking, which is a rarity for me, and to open it up for questions or discussion.

(Kendra Hanley): Jason, this is (Kendra Hanley).

Jason Goldwater: Hi.

(Kendra Hanley): Hi.

I have a point I would just like to make about using the last piece that you talked about for determining the terminology for encounter. There were in fact recommendations from the Health I.T. Standards Committee for that data type encounter.

Jason Goldwater: OK.

(Kendra Hanley): And so, the way we approached these on the E.P. side is that we develop value sets in (snowmed) and then also use CPT. And I believe for the hospital-level measures, they use (snowmed) and then possibly ITB-9, ITB-10 from – for you know for like, the hospital level.

So that's something just to – that we'll need to consider and maybe look at before we go too far down the road of considering alternate terminologies for encounter, although I do think that would still be a beneficial in discussion to have.

Jason Goldwater I concur. I think that you know when we have the talk, with the value set committee, the push was to look at (snowmed), but then again there were some heavy duty terminologies in the crowd that have been working with that vocabulary for many, many years. I think if the recommendations of the standards committee was to look at (snowmed) or CPT for the eligible provider set, which is where we're going to do the encounter analysis from, I think that's just fine to use that as a reference terminology, unless there is somebody in this group that thinks there might be a better way, and I – and you know Kenda, I – I think it's probably wise to go down the path of those recommendations, but I also – if somebody really thinks there's a better way of doing this, we should probably listen to what that is, even if you know we may not go anywhere just because of – of the way ONC might be leaning towards the terminology to use.

There's a question from Jason Jones, what raw data are you going to have to work with?

So, you're not going to be given any raw data, Jason. The Jaccard index will – the card scores will already be figured out for you, because MLM already has an established dash program that they can run against the data itself. They actually did that analysis for us. It saves a significant amount of time. What we would be doing is presenting you with the measures we're going to use. The value sets and the Jaccard index again, and we would only be focusing on these value sets that are.49 and above, because that did seem to be sort of the established threshold that the value set committee looked or agreed with.

So, you will not have a large degree of raw data you're going to have to sort of sift through. We'll do a lot of that pre-work for you before you give you that. And again, some of that is because it's easier to let MLM do this if they have the capability and the other reason is you know we had a couple of years to do

this, maybe we would get into far more complex analysis, but we simply don't have that kind of time.

So, where we can create efficiencies, we're going to.

(Jason): Hey Jason, this is Jason. I – so that effort to answer that question about the level of the wrong (off-mic) but can you give us the sense of you've given us sort of a high level sense of what we might receive, but just more – it's just so much easier sometimes if you know we can get a concrete idea of what we're going to get, especially you know if there are things around like how many people are actually able to submit these kinds of measures, and I don't know if more background on that analysis I think would help is as you point out the manual review is horrifically painful.

Jason Goldwater: Yes, it is. And I'm – Jason, I'm trying desperately to not have you do that.

(Jason): Right.

Jason Goldwater: We've already – we've already done a lot of that, so I don't think you're going to have to.

I wish I could give you a more concrete answer, but we're going to have to run the Jaccard again when the 2015 measures come out.

So, we may have different numbers. I mean, we might have – you know where we had a high Jaccard score before, we might not have such a high one once the measures are done or out.

So, I don't know to the extent. I know that we will have the value sets that are.49 and above so you won't have to do any manual extraction of these value sets. What you will probably end up doing, and we will be able to sort of provide a cumulative distribution on how many people have been reporting on the measures that we're going to use so you get an understanding of that as well. What we are going to be able to present you then is here are all the sub value sets. Here are the Jaccard scores that are.49 and above. You know using your analysis.

So you know if we're doing depression, it would just be the encounters. So using your expertise you know where do you see there being an overlap and why – what reference terminology would go well here to harmonize the ones that you believe need to be harmonized? And when it comes to the hospital measures, again, the only value sets we would be providing then are the ones that are medication-based, and the ones that have a Jaccard score again that are.49 and above, and then you would go into Rx Norm, find the classes of medications associated with those medications that are listed.

You would have the intent. We would provide you with that. That would be coming directly from the developer, and you would be using again your expertise to say "this is – these classes go with these drugs based on my interpretation of that intent."

We don't expect everybody to come up with the same thing. In fact, honestly, we're hoping that you don't, because we want diverse opinions, because that will in turn then give us a basis on how to come up with the best possible and most robust recommendations.

So, I know I feel like I'm talking around the answer, which I'm trying not to do, even though I live in Washington, but I'm – I don't know everything we're going to give you until those measures are published. It might be the very same thing I just showed you. It might be different.

Allison Weathers: Jason, this is Allison Weathers. I'm so sorry. And I think you are trying to – I get you're trying to do the best you can to explain what the information you know. I'm still frankly a little confused about the exact ask and what's involved. I mean is this that something that you would be sending out to us and we'd have access to this database, and then for our next call, we'd come back prepared with – with you know you're going to be giving us a form, and we come back with our assessment? Is this something we're talking through as a group together on the calls?

And then I guess a more philosophical question is as I heard you know you talk about time of days, the large scope of this issue and the impact and then ended with a – a very narrow kind of focus of what we're going to do.

Can you also speak to a little bit how overall to the project you'll feel? Is this sufficient to even help to just – I understand you had to give us something there to be able to accomplish, but I mean it's just looking at the medications, going to ultimately service the larger project, and how?

Thank you.

Jason Goldwater: OK, so let me start with the last question first.

Philosophically, it was sort of determined by the value set committee that if we took on the approach of medications, labs, out-patient, diagnoses, and problems, that is an overwhelming number of value sets to be looking at. It's just a significant number that I'm not sure – I don't think anybody was sure that we would be able to accomplish in the time that this permitted in this contract.

And so the value set committee rethought this through with us a little bit and said, "I think the basis here is rather than looking at a clinical quality measure examining the value set and then developing, or looking at the intent of the quality measure and then developing extensional value sets that correspond to that, why don't we get back to trying to create an intentional value set, which is what you know the (Winnenberg) voting writer analysis attempted to do, which is reverse-engineer the measure to determine the intent of the value set.

So, medication seems to be the best way of doing this because Rx Norm contains classes, which initially it did not. Now it does.

So, they thought if we start with medications, you look, we get the intent from the value set developer of what they were looking to do, and what they were looking to represent. And you understand the intention of these value sets within a clinical quality measure. If you could go into Rx Norm, find the classes of medication that correspond to what's there already and make a determination if the classes of medication are best represented – best represent the intent of the measure and the intent of the value set rather than what's already there, then it is OK to substitute those classes of medication for the extensional list that's already present. And then that way, we begin to understand how to construct an intentional value set which is much closer to

the clinical content of a measure and really gets to the whole focus point of harmonization, which is you want to harmonize terms that are similar or terms that are overlapping into a single concept that best represents of the intent of the measure and the intent of the value set.

And it was agreed by everybody that if we start with medication, that gives us the best idea of how we can do this. It's going to have some challenges because it's going to be relying on how you are interpreting the intent and how you're – how you're mapping the classes of medications to what's already there, and that's fine. You know again, we're not expecting everything to be – to similar. In fact, we are hoping that it's all going to be different.

But it was thought up if we do that, it's enough to at least establish a basis for we can actually harmonize by creating intentional value sets and then hopefully, we'll get – I don't want to be presumptuous, another contract that will then let us focus on the bigger issue of diagnoses and problems, which is a much larger issue, because you have a clinical reference vocabulary in (snowmed), and then you have ICDs, which are commonly used everywhere, because that is the accepting coding for billing.

So that's – I think if we tried to all do that at once, it's just simply too hard.

ONC, when it came to eligible professionals, wanted to do encounters, because they have felt for a long time, that has been a real thorn in their side that they have. And you can almost see by the depression measure that there's some things that probably deserve to be left alone, but then there are some that really probably should be harmonized, and what reference terminology do we use, whether it be (snowmed), whether it be CBT, or perhaps it's something else, in which those terms you feel can be consolidated into one are done that way, and in such a manner again that it represents the intent of the value set and the intent of the measure.

What exactly are we going to provide? We're – this is not – we're going to provide you the data sets that say go at it. We will be reasonably prescriptive about what it is we're going to need, and we will do so in a manner that facilitates input in a way that is not a overriding burden on your time.

So, like I was telling Jason, we will you know present to you the value sets we need you to look at. We're not just going to present: here's every value set associated with AMI. That is over 1,600 value sets. I would not even do that to somebody I did not like, let alone you all, who we have appointed to do this. I would – we'll send you those that are medication that meet the Jaccard score. We'll point you to the Rx Norm database. You'll have access to that, and then you can – we'll show you, we'll write down what the intent of all these value sets are. We will have a form we'll want you to fill out in the analysis that you do, and again we would be looking to make this as thorough but as reasonable as possible. So, it's not, again, where we're passing everything on to you and saying go at it. I think that is, that's something for us to do honestly, but that's not something we would expect the technical expert panels to do.

Because then you're going to be so bogged down in the logistics, we're not actually going to be able to get the benefit of all your expertise.

(Kathy Ivory): This is Kathy Ivory, and I have a question about do we have any or can we get any and it may be that we've got members on this panel that can answer these questions, but do we have any even anecdotal information from folks who have actually tried to operationalize these measures and system, and how that's worked for them and what the challenges have been, because I think it might speak to what we then might want to recommend in terms of interpretation of intent, because we might find that variables as folks are actually trying to use these electronic measures in real life.

So, I guess I – it would be helpful, I think, to have some of that, if we can get that as background as we move forward on this work.

Jason Goldwater: So Kathy, I think that's an excellent point. Here's what we can provide. I think, today. one is we can provide the (bodin rider Winnberg) analysis for you if you have not looked at our unit already.

We will provide you our summary document probably next week of the value set committee meeting, which went over a lot of what you just described,

where it's been done before, what the problems were, why the problems exist, and what people feel needs to be done at this particular point.

That summary document's with ONC now. Once they clear it, which I'm suspecting will be shortly, we're happy to pass that on to you to look at. We are starting to try to poll where this has been done before. It has really not been tried. There's sort of been a – a free-for-all on the creation of value sets, again, because MLM acts as a curator. It is within their purview to evaluate and determine what they want to keep and what they don't, but most of the time, they're curating the value sets for use by measure developers.

So, data sort of us led to where we are now, where there are numerous value sets within the (VSAC), some of which overlap with one another. There hasn't really been any significant effort today on how to harmonize those. There was just an attempt by MLM to reverse engineer the process to try to get to the intent of the value set to determine how to align the appropriate terminology with the measure. So we will share with you that paper and we will share with you, I think we can probably send them, the longer pre-work analysis that was done, so you can see what was done without it being summarized in slides, and then we will send you the summary document of the meeting with the VSC.

If we find something where it has indicated harmonization has been tried, we will summarize that and we'll certainly send that to you, but right now we're sort of in a position where it really has not been attempted, so this is sort of the first major significant attempt by the government to try to reconcile this problem.

(Kathy Ivory): Great, that would be helpful, thank you.

Jason Goldwater: You're very welcome.

Shelly Farragut: Jason, this is Shelly Farragut. I have a couple questions about the medication portion.

First off, on the – on the clinical quality measures, is it really necessary to get down to the actual Rx (Coue) and Rx Norm, or can you – can – because really

Rx Norm doesn't really have an Rx norm class. They use NDFRT or the other classifications that are out there, map Rx Norm to – to the other classes.

So the question is, are we stuck with putting into the CQMs actual Rx Norm or codes, or can we live with a – like an NDFRT classification?

And the reason I'm asking that is when we – when we put the – when people start using these in the systems, if – if the system database has the classification code, then it, and we force them to use the classification code and not necessarily the Rx (Coue) or even a unique code for that, which is the FDA unicode.

(Jason): Right.

What they specifically asked for were classification codes, knowing full well you know that the – the NDCRT was the one that was going to be used, or NDR, NDFRT.

Shelly Farragut: NDFRT? OK.

Jason Goldwater: Sorry.

Shelly Farragut: That's OK.

Jason Goldwater: I think we need that, because that is consistent with what (Libya see as).

Shelly Farragut: Right because there are other – there are other classification codes that map to Rx Norm.

Dual classifications. But I believe that the government was specific on sticking with NDFRT.

Jason Goldwater: That's correct, and that was expressed in the meeting. We will clarify that with Kevin on Friday, Larson, out GTO.

Shelly Farragut: OK.

Jason Goldwater: That did seem to be the direction they wanted to go into.

Shelly Farragut: OK, as long as they know that it's not, because if you had to list all the Rx Norm, you'd have a list that has a big value set.

OK.

Jason Goldwater: Right, so that's what we try to want to avoid.

Shelly Farragut: OK.

Jason Goldwater: Any others?

They are stunned into silence.

So, I – what I want to do is and I want to emphasize this, and Katie would emphasize this as well, as would all of us on the project team, this you know we view it as very much – very much as a collaborative exercise.

I think a lot of you have probably sent – sat on technical expert panels or something of that like where you are convened once or twice, you're asked your opinion, and then that's the end of it.

That is not how we intend on doing that and doing this here.

We all have expertise in terminology in value sets and quality measure development, but we are you know not the reigning experts of this area, and would openly acknowledge that.

We are looking to you all for your advice and your guidance and your opinions on how to make this process work.

So, I want to encourage there to be a continuous dialog between all of you and us as well as you know to share your thoughts or questions at any point in time that you feel is necessary to either Katie or to myself, and then we can work to try to either answer this question or to take into consideration what you've stated as you move forward with defining a methodology, and ultimately defining recommendations. It's very important to us, and it's very important to ONC that what we end up coming up with is something that can be actionable. Like, we can take forward into further developing to include

things such as diagnosis and problems, or whether you know we understand we have to back and start again.

If this does not work it doesn't work. There's the possibility that what we're going to try to do may not be effective, and that's OK. I think we would rather know that now rather than trying to establish something in you know like in a lab, and then not know whether it has any sort of real-world implication or not.

So you know again, we're looking to all of your for your thoughts, for your guidance, for your expertise, and we want this to be a collaborative exercise for everyone from now until the project concludes.

I know we're going to have scheduled talks, abut don't think that the only time you can express something is during that two hours that we're going to speak. If you really have something you need to say or something you'd like to ask or something that you have discovered, by all means, please feel free to share that with us. We welcome that, and that will invariably make the project much better.

Female: This is (Debbie).

I have a somewhat unrelated question. At the beginning of your presentation, you said that (VSET) was going to be publishing the value steps for the measure, the EC2Ms that are coming out next month.

I heard yesterday from somebody in (FEMU.S.) that due to funding issues (VSET) was not going to be publishing this year?

Could you verify, or do you know for sure?

Jason Goldwater: That is the first we have heard of that. So we will jump on that tomorrow, yes. We'll…

Female: OK.

Jason Goldwater: … to (ONC) tomorrow. So that is news to me.

If that is the case, then we're probably going to end up going with what we already have. So we would probably then stick with the same timeline that we've established. But we have not heard anything about that yet.

Female: OK, thank you.

Jason Goldwater: But thank you for bringing that up, because that's…

Female: Oh yes, I mean, that could have a big impact.

Jason Goldwater: Right, on…

Female: Obviously, yes.

Jason Goldwater: On many, many, many entities. Besides our project, yes, that's correct.

Shelly Farragut: Jason, this is Shelly Farragut.

The – are we supposed to be on the – or listen in to the (Value Set) Committee, or do we not have to do that?

Jason Goldwater: You're not required to do that, but I think if you want to the next time we meet them in the fall, you're more than welcome to.

Female: You have a call with (someone) on the 19th.

Jason Goldwater: Right, you're welcome to participate. You're welcome to phone in.

(Shelly), given that you're in Alexandria, you're welcome to attend the meeting.

You can't – since you're not empaneled as part of that committee, you obviously cannot vote on it or make any decisions, but you're certainly welcome to attend.

Shelly Farragut: No, I was actually trying to get out of it, Jason, not go.

Jason Goldwater: Ah, OK. Very – all right, fine.

OK, so you don't have to do anything, yes.

Shelly Farragut: OK.

Jason Goldwater: You don't have to attend the meeting.

But if you want to, though, you're welcome to. We'll pass on that (information).

Shelly Farragut: Thank you. If I have the time, I will.

Jason Goldwater: OK. All right.

(Anne): OK, this is (Anne), and we're just going to do a little housekeeping, talk about next steps.

You should have all received a Sharepoint login from the (nominations) department. Connie should have sent that out to you. I would go ahead and try to login. She should have sent you a link to do so. We're going to (putting) most of our project documents upon the Sharepoint site, and I think we're going to sue the Sharepoint survey tool for some of our work on – (pre-work) on (values). That's the (FORBA call), which will give us you know a real simple way for you guys to run through whatever protocol that we've got and look at some of these problems, so when we get to our calls we will have already walked through some of the solutions and we can use them most productively.

So please log in to Sharepoint. If you have any problems you can either e-mail the Web help address on the slide or you can me directly and I will help you through it.

See, so this is the call schedule for the (Value Set) harmonization technical expert panel. I'm not 100 percent sure if we'll be holding the May 21st call in exactly the same content. We had planned – we will certainly let you know. You should have received invitations to some of these.

And this is the project contact info. This is the e-mail addresses for individuals on the project. You can e-mail any one of us, or you can just send to the general box, (valueset@qualityforum.org). You all see that? Or you can call directly and ask for us and we are happy to help.

Please, like I said, if you could check into your Sharepoint, make sure that you can get in, I'd appreciate. We post most everything to Sharepoint, so.

And that's it from our end. Does anybody else have any questions.

Female: Will you be distributing the slides?

(Anne): We will be posting these slides and a recording of the call the beginning of next week, as soon as we get the call recording.

We will put the slides up on Sharepoint, but they don't have the recording, the mp3, so doesn't quite have the same contextual meanings without the mp3, but yes, the slides will be up this afternoon.

A good reason to check Sharepoint. You can see if you can see your slides.

And then the public site I'll go ahead and send you out a link for that later, which was all the project activities, including everything that the (Value Set) Harmonziation Committee has (planned).

Female: Thank you. At this time I guess we'd like to see if there are any members of the public on the call that would like to make any comments, or if we have any of our federal partners on the line, if they're any comments.

Operator: Thank you. At this time if you would like to make a comment or have a question, please press Star, 1.

And there are no questions or comments at this time.

Female: OK.

(Matt): OK, thank you all very much. We appreciate your time and look forward to working with you.

Female: Thank you.

Male: Thank you.

Male: Bye.

Female: Bye.

END