NATIONAL QUALITY FORUM

Moderator: Value Set Harmonization
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OPERATOR: This is Conference #: 76288305.

Operator: Welcome everyone, the webcast is about to begin. Please note today's call is being recorded. Please standby.

Jason Goldwater: Good afternoon everybody, and thank you very much. Welcome to the Value Set Harmonization Technical Expert Panel Call. We thank all of you for taking some timeout to talk to us today. What we like to do, of course, is to go over the behavioral health project and to talk to you about some of the results as well as the next steps.

First, of course as usual, we're going to start off with a roll call and I will hand that over to our senior project manager Katie Streeter. Katie?

Katie Streeter: Good afternoon everyone. Do we have James Case on the line?

James Case: Yes.

Katie Streeter: Lynn Choromanski?

Lynn Choromanski: Yes.

Katie Streeter: Kendra Hanley? Rachael Howe? Catherine Ivory?

Catherine Ivory: Here.

Katie Streeter: Jason Jones? Russell Leftwich? Kathryn Lesh?

Kathryn Lesh: Here.

Katie Streeter: Caroline Macumber? Priscilla Mark-Wilson?

Priscilla Mark-Wilson: Here.

Katie Streeter: Nick Mattison?

Nick Mattison: Here.

Katie Streeter: Deborah Sita?

Deborah Sita: I'm here.

Katie Streeter: Shelly Spiro?

Shelly Spiro: I'm here.

Katie Streeter: Allison Weathers? Thanks.

Jason Goldwater: So, we want again to review the process, the tools and the task before we start developing and getting into the results a bit. The pilot harmonization process which is established at the beginning of the contract we're done to try to determine the intent of specific value sets, identifying overlaps, duplications, and omissions, and looking to classify from extensional value sets to intentional value sets. And rather to take the entire universe of value sets, we really wanted to look at three distinct clinical areas in which we think that the harmonization pilot process would be effective.

As you all are well aware we started off with medications and this time we move into diagnosis specifically with behavioral health and SNOMED codes. The tools for harmonization were resources, in terms of the vocabularies as well as the value sets authority center, the worksheets that we've developed and sent to you, and the harmonization task.

In this case, it was to look at value sets associated with behavioral health conditions that with the Jaccard index, we're scoring at 49 or above.

The pilot process involved examining the intent, both the intent of the measure and the intent of the value sets that were contained within the measure. To look at overlap duplication and emission manually, in this case that was somewhat difficult to do because of the very large number of codes that existed within the value sets which I think all of you could probably appreciate.

So, we really relies heavily on the Jaccard analysis, and we use the same threshold as we had used before which is 0.9 or above. Those that hit that threshold, we believe were candidates to be examined for potential harmonization and those that fell below were discarded.

Under the direction of CMS, we did not account for ICD codes, CPT codes, or any other, other than SNOMED because that's the vocabulary we were instructed to use. If a recommendation for harmonization was made by any member of the TEP, they had to take – they had to answer why a change was recommended and what they believe the improvement would result if that change was made.

The charge of the TEP was to review the value sets that's associated with behavioral health and determine if harmonization was needed or not, the value sets were distinct that harmonization was not needed or if there was too much ambiguity the decision can not be made.

The worksheet included and it was a little bit more extensive than the one on medications, obviously, this dealt with a more complicated subject but it did include the behavioral health value sets that were included in the measures under meaningful use and other measures that included behavioral health value sets such as emergency department arrival and discharge as well as (VTE).

The worksheet also included the steward of both the measure and its intent as well as the steward of the value sets. We included value sets that may potentially be overlapping based on our Jaccard analysis. We included the object identifier along with the description. We also discuss the steward of the measure as well as the steward of the value sets.

We only examine published value sets within the value sets authority center, once they were listed as either draft or proposed we did not include, and then we included a list of the value sets that may be overlapping and the measures they corresponded too.

The harmonization approach, we asked you all to look at the value sets and examined the measures they come from, the intent of the value set and description, determine that they were either distinct enough and no harmonization was needed. They were redundant and overlapping, their harmonization was needed or the information was too ambiguous to actually reach a decision.

In this particular case, last time when we did medications it was based on our result that we got from all of you, the conclusion was that harmonization was not needed. It was split pretty evenly but after really examining the comments as well as our own analysis of the value sets, we determine that they were distinct enough, at least between AMI, and VTE, and stroke that harmonization was not necessary.

When it came to behavioral health, it was pretty much fairly unanimous for the couple of exception that most of you believe within the measures that we listed that a harmonization was needed, that there was too much overlapped or exclusion of codes, and that there was too much redundancy and as a harmonization approach really should be discussed here.

The first one we dealt with bipolar disorder which came from the Minnesota community measurement. I won't really get into all of this. There were a lot of comments that were made, some of them we just took directly and extrapolated right on to the slide. Others we tried to synthesize as best as we could, and in some cases when there was a reason for harmonization that was unanimous there was no comments on why harmonization was not needed.

So, in this particular measure, some codes were excluded from the SNOMED CT set including those indicated full remission, partial remission, and intermission, there was significant redundancy in the value set across the SNOMED codes for bipolar disorder. If you examined the value sets within –

or examined the codes within that value sets, there are a number of overlaps and a number of repetitive values, and a number of codes that are overlapping and redundant as well. So, this one was determined as a candidate for harmonization, rather.

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The behavioral health condition evolving bipolar disorder which was also classified in SNOMED and this came from the Center for Quality Assessment and Improvement in Mental Health. Again, just focusing on the reasons for harmonization because there was significant consensus that this should be another harmonize measure, there was no reason for organic bipolar disorder. It should be excluded, schizoaffective disorder bipolar type is a bit more a tentative but it's (model) in SNOMED CT as well as the bipolar disorder and schizoaffective disorder in SNOMED CT.

There were a number of competing codes and overlapping and some codes that needed to be included in one value set and we thank Kathy Lesh for her very insightful comment in this regard.

Next slide.

The other one was bipolar diagnosis for SNOMED for the quality insight for Pennsylvania, the comments that we did get back every one seem to think that this was another candidate for harmonization, largely because there were some codes that were excluded that really need to be included in one value sets and there was no reason why there's some of these codes were absent. So, they really needed to be one harmonize value sets that really dealt with bipolar diagnosis.

Now, if you really looking for value sets more closely, you can see that there is roughly about 800 value sets that corresponded bipolar diagnosis. So, there's clearly some need to harmonize these and the things that are a little bit more distinct.

The psychiatric mental health patient which came from my (antenna), again, without really getting into all of the details here, again, most people thought

this was one needed to be harmonize, a lot of these value sets really did not contain enough distinct value to separate mental health disorders and substance to be use. And again, there were codes that were excluded as well as being redundant.

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Mental disorder which came from the joint commission which was SNOMED CT, this will be interesting because the joint commission is also on our value set committee so we will certainly hear what they have to say about the analysis was we presented to them.

But again, in much the same way is the analysis is falling out and the comments that we did get. And again, thanking Kathy Lesh for these insightful comments as well which seem to be very familiar as well as very consistent with the other comments that we received. There are a lot of these value sets for psychiatric mental health patient, mental disorder, mental heath diagnosis really should be harmonize so that there is some distinction between the value sets for mental disorders, mental health disorders as well as substance abuse.

The mental health diagnosis which came from NCQA, there are also on our value set committee, so we'll see what they have to say about this as well. Again, it was the same exact comment that there is just needs to be a more harmonize value set that there is not a lot of distinction and there's a lot of overlap in the value sets that are part of this along with other corresponding value sets that there is not enough distinction to warrant not harmonizing.

And then the synthesis of behavioral health resorts – this is a behavioral health condition involving unipolar depression which was also in SNOMED and this came from the Center for Quality and Substance and Improvement of Mental Health and the codes that value sets were list under this, really needed to be harmonized because of overlapping the behavioral health condition involving unipolar depression, major depression and then the depression diagnosis that's active in SNOMED. It should also be noted that when we did our pre-work

analysis, prior to engage in the pilot test, we came up with this very same results.

And then major depression or major depressive disorder which also came from NCQA because it's not harmonize, there are a lot of different value sets that are not being included in this and as a result they're really needed to be in order to align more specifically with the intent of the measure itself.

And then major depressive disorder in an active state which came from the AMA or PCPI, again, if they're really intended to only include major depression or major depressive disorders, it really should use just one consistent value set to have the appropriate codes in it.

And then depression diagnosis, this is when a couple of people felt that it should not be harmonize but their rationale given was, if this particular codes that are currently excluded from the value set, if they were out purposely excluded, we need harmonization. And right now it's very difficult to tell whether they were excluded purposely or they were just simply excluded because the measure developer was creating a value sets without knowledge of one that are already existed which is did someone have a recurring problem which is why we are doing this exercise.

So, again, the concepts of your bipolar 2 disorder and other depressive disorders need to include the appropriate code sets, the ones that are currently they're excluding necessary ones that would align with the intent of the measure or have ones that are redundant with other value sets.

This is pretty much been consistent in everything that we got from you and everything we saw ourselves. There are a variety of comments. You're welcome to look at them more specifically, but essentially when it came down to is there was an overwhelming consensus to build for harmonization due to too much redundancy and overlapping the already existing value sets as well as codes that were being excluded that were necessary to align with the measure.

So, what exactly our next steps, we're going to work with our value sets committee to determine a methodology for harmonization based on your recommendation and we'll discuss that with you prior to sending out the next assignment. The objective in task of the VSC is to recommend the harmonization process, once we have that we will discuss that with you and then we'll begin to undertake that and show with the results are.

We are currently working on your third pilot test, and when see we'll look to discuss that with you in a next couple of weeks. We don't really know what that's going to be yet, we certainly wanted to be something that will be unique but also something that could be done within a very reasonable amount of time. We're very aware of your time restrictions and then some of you may know we are on the last leg of this project and are looking to consolidate the results into a final report.

We're scheduled to have a second in-person meeting with the value set committee November for review the results of all three pilot test. We'll discuss the harmonization process and we'll also start to discuss the governance models. Once we have sort of a final draft to that we will discuss that with you as well to get your input. The reason we want to look at governance model is the ways of ensuring the we have high quality value sets that we're able to harmonize and remove potential redundancy, make sure the appropriate codes are included to align with the intent of the measure and to see if there's a way that NQF would actually be able to enforce this through its consensus development process.

And then finally we are beginning to draft your final report and we'll keep you informed as we move through that.

The next value sets harmonization technical expert panel webinar will be in early October, I know that Ms. Phillips and myself will be at HL7 meeting in Atlanta, some of you may be there. If you are going to be there, please let us know and we'll see if we can get a room for all of us to convene while we phone in those who are dialing in remotely and actually might be nice to have some face to face interaction as we discuss these results.

I believe that is it. Are there any questions if anyone has, again, thank you all very much. I realize this was a bit more onerous the task and the medication one because of just a pure complexity of the value sets as well as the very large number of codes.

So, for those that took that time to really look through this which was all of everybody on this call. We thank you very much and appreciate your comments and insights. They were very, very helpful and helping us reached a conclusion and I know ONC will certainly be pleased with what we were able to uncover.

Any questions?

Female: You explained it incredibly wow.

Jason Goldwater: Really, I'm on a roll today, seriously. I talked to a panel of health services researchers at 9, they had a million questions but they're (pulse) services researchers. So, always nice to talk to people that are informaticist. It's pretty (cut and dry).

All right, well if none of you have any questions. We thank you very much for your time. We will keep you informed on our harmonization process. We will also keep you informed after what we're doing with respect to governance. And again, if any of you are going to be in Atlanta for the HL7 meeting, please let either Anne or myself know. If there's a large group of us we will make sure to get a room so we can all get together. It would be nice to meet some of you in-person as well as I think it might be nice to have face to face interaction with some of you as we move towards the end of the project.

Thank you all very much for your time. We look forward to talking to you again.

Female: Thank you.

Female: Thank you.

Female: Thank you.

(Off-mike)

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

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