

**Vocabulary Task Force and Clinical Quality Workgroup**  
**Draft Transcript**  
**August 29, 2011**

## **Presentation**

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good afternoon everybody and welcome to a joint meeting of the clinical quality measures workgroup and vocabulary task force. This is Federal Advisory call so there will be opportunity at the end of the call for the public to make comment. Workgroup members please identify yourselves when speaking and if you're not speaking please put your line on mute.

Let me do a quick roll call: Jamie Ferguson?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jim Walker?

**James Walker, Chief Health Information Officer, Geisinger**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Betsy Humphreys?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Stuart Nelson?

**Stuart Nelson, National Library of Medicine**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Marjorie Rollins? Stan Huff? Chris Chute?

**Chris Chute, Mayo Clinic**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Mark Overhage?, Daniel Vreeman?, I think for Floyd Eisenberg we have Beth Franklin on, is that correct? Don Bechtel? Patricia Grimes?, Chris Brancato?

**Chris Brancato, HHS/ONC**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Andrew Wiesenthal?, Bob Dolan?, Bram Sarong?, Ken Gephardt?, Lynne Gilbertson?, Nancy Orvis?, Marjorie Greenberg?

**Marjorie Greenberg, HHS/CDC**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Karen Kmetc is going to be in and out of the call. Anne Castro?, David Lansky?, Eva Powell?, Phil Renner?, Andy Rosenthal?, Rosemary Kennedy?, John Derr?

**John Derr**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Pam Cipriano?

**Pam Cipriano**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

John White?, Aneel Advani?, Did I leave anyone off?

Ok, I will turn it over to Jamie Ferguson and Jim Walker.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Thank you Judy. I will say a couple of words and hand it off to Jim. I think everybody on the call remembers, we made a set of recommendations to the standards committee in the last committee meeting and those recommendations were accepted. But, we also said, as part of the presentation, that we would develop a plan for transition plans. And an approach to them and come back with report to the committee in the September committee meeting with an overview, a plan, and a strategy for achieving transition plans to the long-term target vocabularies where such transitions are needed and to lay out the actual transition plan to the extent possible. The overall requirement for the September meeting is to show progress and not necessarily to have all the final answers. Does that sound right?

**James Walker, Chief Health Information Officer, Geisinger**

Yes. I think there are probably some core issues that we want to try to have well down the road, and we don't expect to get it all done by then.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Jim, do you want to take us through?

**James Walker, Chief Health Information Officer, Geisinger**

Sure. I would be glad to. Slide 4, the background is to require the immediate exclusive use of some of the standard vocabularies might be so burdensome as to compromise measure development. That is what all of this is focused on is vocabularies for measured development. So, that goal for today and tomorrow is to identify acceptable interim vocabularies for the specific data categories of the quality data model. Again, to support clinical quality measures development. And, this scope is just another iteration of that. The next slide has the questions. It seemed to me that we needed to address these today. The first is to discuss whether the proposed interim vocabularies are needed. As you see, when we go through the

slides, for probably 8 or so of the 23 categories, interim vocabularies are recommended. We want to address those that have been recommended first. The first issue is to get a sense of the workgroup. If, in fact we need those interim vocabulary for those data categories. Then, the second question, as we come back through it, were there any of the other data categories that members of the team thought we needed an interim vocabulary that had not been recommended. And then, going back to all of the ones, we identified them as needed, I think we want to identify what the minimum necessary information about the transition that we need to specify. Probably, the length of interim, certainly, if there is available value sets that make use of the vocabularies more efficient and effective, and then mappings and any other questions. We will come back to that last. If we can go to slide 6 and maybe I should pause there. Please go back to slide 5. Does that sound like a reasonable way of approaching this? Are there any comments or recommendations?

Okay. We will move on to slide six. Again, thank you to Pam Cipriano and Tom Tsang and all the other ONC people who set this up for us to make it possible for us to address this efficiently. Okay. On slide six, the first concept, or data category is allergy, and you see the recommended vocabulary there and the note that, at this point at least, we have no recommendation for an interim, acceptable vocabulary for allergy. Again, if anybody on the call believes we do need one, make a note to yourself and we will go through these the second time for that. Then, slide seven –

**Eva Powell**

Jim? I had my phone on mute. Just a quick question, not so much relative to our process today but just from my comprehension of how things knit together, how is the work of these two groups knitting together with the work of the S&I framework workgroup? I've also been involved there and while we are working on different things, they are closely related. I wasn't sure how these things knit together.

**James Walker, Chief Health Information Officer, Geisinger**

I will answer quickly, but someone who knows more, Tom, Pam, or Jamie can refine it. I thought S&I were counting on us to do the work.

**Pam Cipriano**

That is correct. We are working closely with this and my staff and some of them may be on the call. Yes, this is a piece of the work.

**James Walker, Chief Health Information Officer, Geisinger**

Okay. We appreciate that question. If you want to raise issues where we really need to think about making that dove tailing really effective as we go through this, please do.

**Eva Powell**

I wanted to clarify that in my mind. I, unfortunately, will have to hop off in a little bit.

**James Walker, Chief Health Information Officer, Geisinger**

Any other comments? Did anybody else find the mute button?

Then, slide seven is another one where there had been no interim vocabulary recommended yet. I will not read all the vocabularies we recommended and the standards committee accepted be used for characteristics. The next slide, the first category or concept is communication and as you see there there's no interim vocabulary recommended at this point. The next concept, condition diagnosis problem, we do have the recommendation that for an interim, ICD-9 and ICD-10, would be acceptable vocabulary. Just another process, I separated all these recommendations. I think it will be easier for us to address

each vocabulary separately and I recommend we do that. Any thoughts about ICD-9? One of the things I want to do on the call is to document reasons that an interim vocabulary would be required and then any other things we think would be helpful to explain the case to the standards committee and others.

**Chris Chute, Mayo Clinic**

I want to be clear on what we mean by interim. Does that imply, say for phase 2, we have an or condition for ICD-9, ICD-10, or SNOMED? Would that be the practical interpretation?

**James Walker, Chief Health Information Officer, Geisinger**

Yes, the point of interim and for some interim, which is part of our work to determine, it would be acceptable to use in this case ICD-9 as well as SNOMED, the long-term standard vocabulary.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

The real thing would be for the interim you could use ICD-9-CM or SNOMED. For subsequent piece of the interim you could use ICD-10-CM or SNOMED?

**James Walker, Chief Health Information Officer, Geisinger**

I think it will be easier, although we are discussing it, if we said for instance, ICD-9 would be acceptable from 2012 to 2014 and ICD-10 would be acceptable from 2012 to 2015. They might be overlapping, they might be sequential depending on our best judgment to the merits of the case.

**Marjorie Greenberg, HHS/CDC**

Well for clarification, say for example you can use SNOMED or I9, but if you are able to use SNOMED, you should using it? Is that what's expected?

**James Walker, Chief Health Information Officer, Geisinger**

My understanding is that no one would be trying to enforce it. But if you could use either SNOMED or any interim code, you would better off using SNOMED so you didn't have to manage a transition from the interim to SNOMED.

**Marjorie Greenberg, HHS/CDC**

Okay, but I do anticipate that question.

**Chris Chute, Mayo Clinic**

It raises the question of recipient capability. Let's say as a provider, our organization, Mayo Clinic, was able to provide SNOMED, which incidentally we would have trouble today, who would receive it? As soon as you introduce these or conditions, it's not just the generator, you also have to think about the recipient target particularly in the meaningful use health information exchange context. How are we going to reconcile the likelihood that we have a dissonance between receiver and sender if there is more than one specification?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I entirely agree that it is a very important point and want to clarify a couple of things. One is, since we have to do this for quality measures only, right? Who are we assuming are the intended recipients? Is it only CMS?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

My understanding is that the intended recipient is only CMS for meaningful use. This is essentially a specification that will be applied within the measures.

**James Walker, Chief Health Information Officer, Geisinger**

I believe the intention of this is the measure developers would develop in SNOMED unless there is a powerful reason not to and CMS would be the recipient.

**John Derr**

Since we get 40-60% of the people, we are not prepared for SNOMED and ? So, it would have to be just CMS.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Within the context of the meaningful use and the law, we are talking about the reporting of quality measures, the law is referring reporting them to CMS, is that correct?

**James Walker, Chief Health Information Officer, Geisinger**

I believe that is correct.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

It is true that people might also be reporting them to other people for other reasons, but the requirement here would be for CMS. Then of course to Chris' point before is very different from other parts of meaningful use where you are sending information in a transaction and there is a whole range of players that have to be able to receive it. The other question I have is these quality measures. The years that Jim gave that would be overlapping applicability of 9 and 10 CM as one of the options, I guess that makes sense given when people would have computed these things and have to report them?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Certainly, for administrative simplification, we are already in a dual use period, right?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Yes.

**Stan Huff, Intermountain Healthcare**

What this is saying even in that limited context is that CMS has to be ready to receive ICD-9 or ICD-10 or SNOMED. Everybody else will choose one, the senders would just one and hopefully SNOMED if they can. CMS would need to support receiving any of the three.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Yes. It's an "or" for the sender and an "and" for the receiver.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

You have to imagine a scenario on some of these things where you'd have to imagine that all cases could exist. There might be a case where, for some measures you could use SNOMED CT if you were the sender and for others for whatever reason you aren't ready to do that yet.

**James Walker, Chief Health Information Officer, Geisinger**

I think the idea is that many organizations might be able to send ICD-9 but not SNOMED. There might be a few organizations that made the transition to ICD-10 soon enough that they would prefer to send that, but they are not ready to send SNOMED yet.

**Pam Cipriano**

We have been sharing all of this work on a routine basis with CMS staff in the quality measure area. They have not raised an issue of not being able to receive SNOMED. Again, for FYI background, they are

aware of the code sets we've identified and we will be recommending transition. We have asked them to comment on anything they would like to and there have not been any significant issues raised.

**James Walker, Chief Health Information Officer, Geisinger**

Great. With the very helpful clarification, thank you that it is options for senders and would be a requirement for CMS, but that CMS appears to be ready to try to execute this. Are we comfortable then with having ICD-9 and ICD-10 be interim vocabularies for condition diagnosis problems? Any other discussion?

**Aneel Advani**

Just following the same set of issues, clearly, our work here in the conversations that we've had is primarily focused on authoring and specifying the quality measures. In terms of the data flow that supports those answers to those queries, are we suggesting that clinicians, when they are actually recording clinical realities through vocabularies, are not affected by our choice of standard? In other words, right now, folks in HIS, we are upgrading to ICD-10 and we are putting ICD-10 concepts in drop-down lists that clinicians would have to be aware of, understand, absorb in order to actually directly record clinical observations into the electronic health record. They will have to be able to compute ICD-10 as clinicians. In evolution towards SNOMED, are we really saying that, as long as the reporting in SNOMED, clinical reality doesn't have to go past ICD-9 or ICD-10 when physicians or clinicians have recorded directly or observe and think through authorizations, or are we really saying, we want to evolve to a point at which clinicians are observing reality and recording reality in SNOMED because that is actually more of a constraint and more ambitious goal. I'm not sure if we have been clear about those 2 when we say the sender needs to be sending SNOMED as a choice?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

There was quite extensive discussion about this in the standards committee. It was really from the perspective that CMS actually wants to ensure that the quality measures that they receive are sufficiently accurate. So, for purposes of this recommendation what we are saying is that clinical, original documentation at the point of care, can be whatever you want it to be in your local environment so long as you're able to produce sufficiently accurate representation of our observation or reality in SNOMED alternately and in the interim period in ICD.

**Aneel Advani**

Since SNOMED is more detailed than ICD-10 and more than ICD-9, you're basically just sort of having this interrelation bias by adding more detail when it wasn't recorded in the first place? So anyway –

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

That's a potential issue, it depends on the measure developer's to use points in SNOMED that are at a sufficient hierarchy level that they could be represented in the other vocabularies, at least during the transition period.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Isn't it true that the discussion in the standards committee, some of it was emanating from the other end where they actually expect that they would have for at least some of the elements required for the measures clinical texts that they might be converting to SNOMED CT rather than having something like 9 CM that they were converting?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

That is correct.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I had even more detail.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think there was discussion, and there certainly are some committee members who are using or planning to use various methods to essentially convert the text into SNOMED.

**Aneel Advani**

The other point I wanted to make is on the last, when we say who receives this, I think at the department level, there are different architectures for quality reporting that are being badgered about. There is some effort, in terms of cooperative groups, etc., to evolve towards an interoperable quality registry type of model where you have some data intermediaries. That's a little bit different from raw data going directly to CMS where the sort of intermediate registry entities would be target of standards development. So, that's one thing to think about as we evolve in the next couple of years or have recommendations of that sort. At least 2 if not more years, is this idea of data intermediaries aggregating quality or raw data and then reporting out of that step, whether it is HIEs or care providers or QIOs. That entity might be a target for this type of standards development as well. Is not necessarily just CMS as the repeater of raw data.

**James Walker, Chief Health Information Officer, Geisinger**

I would guess those intermediaries, a key part of their value proposition, would be adept at handling multiple languages.

**Aneel Advani**

Yes, that's totally a value added data validation.

**James Walker, Chief Health Information Officer, Geisinger**

Okay. Great discussion, thank you. I think I number of useful clarifications. Are we comfortable then on condition diagnosis problem that ICD-9 and ICD-10 would need to be acceptable vocabularies for some interval yet to be determined?

**Marjorie Greenberg, HHS/CDC**

Yes. I think if we are going to put out a public document, it should be clear that it is ICD-9-CM and ICD-10-CM and what the years are. I'm not sure that CMS will want to be collecting or receiving 10-CM before it has to be implemented on Oct. 1, 2013. I don't think after that they want to get 9-CM.

**James Walker, Chief Health Information Officer, Geisinger**

They may not want to, but would they need to to be useful? Different question.

**Aneel Advani**

If you're doing a quality report over two years, you may not have started gathering ICD-10 CM before October 2013. You may have an overlap period of two years.

**Marjorie Greenberg, HHS/CDC**

That's true. They wouldn't want to get 9 CM data that was produced after October 2013. I misspoke that probably. Obviously, they will have to get, depending on the time period of the data, it should track with what the approved code set was.

**James Walker, Chief Health Information Officer, Geisinger**

I think setting the intervals thoughtfully is going to be key to making this work for people. I think when we come back to this, we have to think carefully about what will the intervals be that will be reasonable from both sides of the transaction. Unless somebody else wants to make a comment, I think we will regard that one as done and move onto slide –

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Before we move on, we talked about the what. But, we haven't talked about the other aspects of the transition plan that would be more of the how. In other words, in this particular case, cross maps being made available through an authorized office or agency where a part of the recommendation. I think, if we are talking about a transition plan, it shouldn't only just say, move from here to here on this date, but something about the how it is intended to be accomplished and what tools are available to implementers.

**James Walker, Chief Health Information Officer, Geisinger**

Absolutely. That is what I was trying to get with question three. I thought it might be easier, if identified all the ones we thought needed a transition. I think if we went through and saw all of the ones we need to do we might be faster doing the specifics because there might be considerable reusability of elements that would make it easier to move through the specifics once we saw the whole task.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

No problem.

**James Walker, Chief Health Information Officer, Geisinger**

Why don't we try it anyway. Slide nine. You are right, there is a lot of specification needed. For devices, the first concept there, there isn't a currently recommended interim vocabulary and the same is true for diagnostic studies. Again, I wanted the team to see these, have a chance to say yes that make sense and we don't need one there. So, we are then pretty sure we're not missing something for the next phase. Slide 10. For encounter, the artisan to be named patient professional interaction, the current recommendations are for three interim vocabularies. By the way, thank you for the comment about CM when we get this ready for public presentation we will want to make sure that we get all of those things right. So, the recommended interim vocabularies here are CPT ICD-9 procedures, and ICD-10 PCS. Any comments/thought about the appropriateness for CPT?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I think it's appropriate. I think that's where a big chunk of the world we care about is at the moment.

**James Walker, Chief Health Information Officer, Geisinger**

A similar discussion about ICD-9 procedures and ICD-10 PCS. Do we believe we need both of those?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

What we are talking about here is what's in the current measures that are currently required? These are interim measures, so they are currently required and needed for a period of time until different measures are instituted instead.

**James Walker, Chief Health Information Officer, Geisinger**

Great. Pam, you got that as the reason we need these?

**Pam Cipriano**

Certainly.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

It isn't true of ICD-10 yet is it?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think that is true. I don't know the measures where these are used.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Have they actually moved ahead to start encoding them in 10 CM and 10 PCS yet?

**Marjorie Greenberg, HHS/CDC**

Yes, we did provide coding last year.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Okay.

**James Walker, Chief Health Information Officer, Geisinger**

The concept experience, there is no interim vocabulary recommended. Let's move to slide 11. The first concept family history the recommendations come ICD-9 and ICD-10 for the interim. Is this fundamentally the same discussion that we had before? Are there different aspects about family history that we need to discuss? Does the team regard these two as necessary for some interim period?

**Unidentified Man**

Yes.

**James Walker, Chief Health Information Officer, Geisinger**

Is there any dissent with that? If not, we will move on. The next concept is functional status. Currently, no interim vocabulary is recommended for that. Slide 12? The first concept, health record component, no interim vocabulary is recommended. And then, for intervention, which may become procedure, we have three interim vocabularies recommended, as before CPT ICD-9 procedures, and ICD-10 PCS. And then, there was a question about CVX vaccination was appropriate in some interim. Are there anything different about CPT ICD-9 procedure, and ICD-10 PCS with respect to this category?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I don't think so.

**James Walker, Chief Health Information Officer, Geisinger**

If everybody is comfortable, maybe we come to the same conclusions on them here as we did before. That they are necessary and the question is, is CVX necessary for some interim for vaccinations?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I know in stage one of meaningful use CVX was used for public health reporting of immunizations, but I wasn't aware that it was used and quality measures.

**James Walker, Chief Health Information Officer, Geisinger**

Does anybody else on the call know that?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I think the issue is that sometimes CVX is used in the context of being the actual vaccine that is delivered and in some other cases is used to denote that the procedure was done.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think that is correct. But, whether a transition is needed here or not, does that need depend on whether or not it is used in current measures?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Of course it would. Sorry.

**Marjorie Greenberg, HHS/CDC**

From our retooling work we did last year, we did not provide CVX codes. I can't speak for other measure developers though.

**James Walker, Chief Health Information Officer, Geisinger**

I guess the other question, would this be like ICD-9 where it would be the vocabulary that some organization would CVX be the category what someone organizations would be able to use? The only one that they would reasonably be able to use for some interim period. I don't know the answer, but I think the question is important to address.

**Pam Cipriano**

We can certainly find out. NQS did not recommend CVX for vaccination. It was on the previous discussion in the workgroup as we are working to the concept at one point. This was listed as a potential interim. What we can do is, go back and look and see if it is in any current measures, if it is, continue to keep it on as an interim, if not, recommend back and take it off.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

What I would suggest is that we take it off subject to confirmation.

**Pam Cipriano**

That makes sense.

**James Walker, Chief Health Information Officer, Geisinger**

Great is everyone else comfortable with taking it off pending confirmation that it is needed?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Absolutely.

**James Walker, Chief Health Information Officer, Geisinger**

Slide 13. Here, intolerance, noting its probable new name, there is no currently recommended interim vocabulary for it.

Slide 14. Laboratory tests, there are also no interim vocabulary currently recommended.

Next, 15.

Okay. Similarly for medication and physical examination, there is currently no interim vocabulary recommended.

Slide 16. So, also for patient preference, there is no interim vocabulary the recommended but then when we come to the concept procedure we have the recommendation of CPT ICD-9 procedure and ICD-10 PCS.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I have a question about the current set of measures. Are there any that use ICD-10 PCS?

**Marjorie Greenberg, HHS/CDC**

Again, we did not use 10 PCS last year.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Is it reasonable to take the same approach to remove 10 PCS pending confirmation that it is not used in any measures currently?

**Chris Chute, Mayo Clinic**

That's a slightly different vaccination. It is possible that at some point in the future, PCS would be used after the ICD-10 transition. It begs the question of whether we would expect people to go to SNOMED at the same rate or slowly or more quickly than they go to 10 PCS. I am inclined to leave 10 PCS on the likelihood that when in 2013 we do adopt it nationally, quality measures correspondingly include 10 PCS for procedures.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

If it is not used in any current measures, and we know the target is something different, why would we purposely develop new measures that are not to the target?

**Chris Chute, Mayo Clinic**

Because the forces that providers and others are going to confront requiring the ICD-10 transition I submit to you may be more compelling than the average provider then those that would require a parallel commitment to SNOMED, if only for quality measures. They will adopt 10 PCS no ands, if, or buts. They are required to for reimbursement as of 2013. It is not entirely clear to me that it's reasonable to expect all providers to simultaneously embrace SNOMED for procedure coding just for quality measures.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think this also gets back to the discussion that we had in the standards committee. I think what we are talking about is requiring it in quality measures for purposes of EHR certification as well. So, if EHR certification is used as a tool to facilitate that migration from, for example, 10 PCS to SNOMED for purposes of producing reports, then it should be painless.

**James Walker, Chief Health Information Officer, Geisinger**

It seems to me that Chris is right in the sense that this would not require ICD-10 PCS to be in measures or to be used by anyone, but if there were organizations that were capable of using reporting in that language and not any other, that we would not want to prevent them from reporting. So, to be acceptable but not required.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

And, to a Jamie's point, and what was discussed in the standards committee, from the point of view of the EHR developer and the recipient, they have to support multiple things.

**James Walker, Chief Health Information Officer, Geisinger**

Why would it require that the EHR vendor do that?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Well, if you are going to say that it is allowable for me as a particular organization to compute and report my quality measures for some period of time in ICD-10 CM, and I am using that for billing and that's the way I want to go and I don't want to go to SNOMED CT or I think it's too much trouble, I don't see how the vendors if they want my business don't have to implement ICD-10 into their quality measure category as well.

**James Walker, Chief Health Information Officer, Geisinger**

They might be forced by the market, but that's different than us requiring it for certification.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I was referring to PCS.

**Marjorie Greenberg, HHS/CDC**

It doesn't make sense to me, for the same time period that you would allow 10 CM, you should allow 10 PCS. There is a point at which you don't allow either and you say it has to be SNOMED. It doesn't make sense for people to go to SNOMED for interventions, why we are still allowing them to use 10 CM for the diagnosis side.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think the difference is, 10 CM is currently part of the meaningful use regulation whereas 10 PCS is not.

**Unidentified Man**

There is a non-parallelism there. We all know in 2013, hospitals and providers will be required to provide, at least this is my understanding, ICD-10 CM as well as ICD-10 PCS.

**Marjorie Greenberg, HHS/CDC**

For inpatient. Maybe most of these quality measures or all of them are not for inpatient. If they are for inpatient, then yes, 10 PCS –

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

That's an interesting point. It does seem that if some of the measures are for inpatient and some of the measures are for outpatient and some are for both, then, whether you would feel that 10 PCS was a legitimate interim requirement or interim possibility, might very well be whether the measure had anything to do with inpatient care or not.

**Marjorie Greenberg, HHS/CDC**

It never would be appropriate for anything but inpatient. That is what it was required and designed for.

**James Walker, Chief Health Information Officer, Geisinger**

Can anybody on the call explain a case where use of PCS would be acceptable for some period of time? Not required, but acceptable?

**Unidentified Man**

Well, Jim, it comes down to what extent we expect uptake of SNOMED. Marjorie's point was, we are not necessarily expecting the uptake of SNOMED on the part of the ? for diagnostic concepts, but, there is a non-parallelism here, that if we do not accept 10 PCS on an interim basis, then we are expecting the parallel uptake of SNOMED with CV 10 conversions on the part of providers. And remember, it's not just the vendors it is the providers that have to generate these codes and understand them and be familiar with them at the source of generation. I'm simply raising if we are doing it for diagnostic codes, why are we doing it for procedure codes?

**James Walker, Chief Health Information Officer, Geisinger**

Okay. So the reason would be that, no one would be paid if they don't go live with ICD-10 and the uptake with the extremely high. The amount of payment that is at issue, if you don't use SNOMED initially would be a couple percent. And, it's entirely possible if some organizations will look at the resources and just not

be able to do both together. So, there will likely be a time for some organizations, rightly or wrongly, when they have 10 and not SNOMED. Is that is what you're saying?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

That sounds right. I think when we come back and talk about the mechanisms to enable and facilitate, and frankly make easier the transition to all of these target sets, I think we need to figure out what our recommendation is going to be around of making the transition to SNOMED for these particular purposes easier by including some aspects of technology that would enable the transition in the certification process. I think you can say it's a circular argument, it can go either way. Essentially, if we just require SNOMED and say it will be mandated for EHR certification, that makes it a lot easier for many providers to use it for the purposes.

**James Walker, Chief Health Information Officer, Geisinger**

Right. Okay if I'm reading the sense of this meeting correctly, our sense is that we want to include all three, CPT, ICD-9 procedure, and ICD-10 PCS as acceptable interim vocabularies and the questions will be how long and with what aids to make transitions.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I think we should remember, probably when we are setting this up, to actually comment that the distinction that CPT is an appropriate interim or outpatient practice-based care and that PCS is only an appropriate interim for inpatient. Just to be clear to people who don't understand.

**James Walker, Chief Health Information Officer, Geisinger**

Thank you. Pam, did you get that okay?

**Pam Cipriano**

I did.

**James Walker, Chief Health Information Officer, Geisinger**

Thank you Betsy. Is that acceptable as the sense of the discussion?

**Asif Syed**

I have a quick question. How are the interim vocabulary going to be recommended? Is it going to be part of the recommendation or a part of the transition plan?

**James Walker, Chief Health Information Officer, Geisinger**

I think we need to be careful about language. I think they are going to be acceptable, but not recommended. And then, the questions that we will get to is, how do we make their use, since they are acceptable, make it possible for them to be used with some efficiency?

**Asif Syed**

Technically, they are recommended for a selective purpose.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Actually, I don't think so. We made our recommendations, which are the final target set which were accepted by the committee. Now we are coming back with transition plans to enable everybody to get there. So, I agree with Jim to make them acceptable on an interim basis, but it is not part of our recommended vocabularies.

**Asif Syed**

This is not going to be recommended.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

We are talking about two different things. What we are talking about here is, what the sub-groups will recommend to the committee and then they will decide how they will convey this to the national coordinator. In the end, the issue is going to be, what does rule making around this look like? Which will be a separate thing.

**James Walker, Chief Health Information Officer, Geisinger**

So, for one concrete thing, the length of the interim recommended will communicate very powerfully, if the interim were 10 years, that would be very different than if the interim were one or two years. So, I think that will be one thing to communicate to people how much it makes sense to focus on these. I guess our idea is, the only people for whom it would make sense to use these acceptable vocabularies are people, who, for some other reason, are already using them and it would be difficult for them to use anything else for some interim.

**Asif Syed**

Okay.

**James Walker, Chief Health Information Officer, Geisinger**

I think that's a good point. That's probably going to be difficult to be too clear about this. If we, and ONC together, whoever, can create an extremely short white paper that will put this into context that a healthcare organization leader could be expected to understand, and then help this organization act on it, that would be useful.

**Asif Syed**

We don't want to confuse the market.

**James Walker, Chief Health Information Officer, Geisinger**

Exactly.

**Pam Cipriano**

I think Betsey's comment is probably the most important. These will go forward to inform the interim rule, so whatever gets put into the interim rule is the point at which then there will need to be a guidance paper.

**James Walker, Chief Health Information Officer, Geisinger**

Great. So you're just saying that would be a normal expected part of the process Pam?

**Pam Cipriano**

Yes.

**James Walker, Chief Health Information Officer, Geisinger**

Great Okay. Are we good on the slide 16 then? That's go to 17. So, for both risk evaluation and substance, there are currently no recommendations for an interim vocabulary. Slide 18. Again, for symptom and system resources, no interim vocabulary is currently recommended. And then, slide 19? Also, for transfer, there is no interim vocabulary currently recommended. And I think 20 might be the last category. And, slide 20, and, you know, the order that these came in. It might be reasonable to go ahead and dispose of this. This really doesn't quite fit the rest of what we are doing. This is a new proposed

concept called care goal. And, we didn't include this in our initial work because it wasn't on the project plan but it will be in the measure offering tool. QCF and ONC were looking for us to include this in the recommendations. The recommendation would be that it is SNOMED. So, two options either this is obvious where we do not need much discussion or maybe we should table it and come at it after we have done the transition planning. Any thoughts on that?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

If I am not mistaken, part of this comes from the care goals for where you want the patients to be in terms of nursing care goals, in terms of their ability to function or whatever. Am I correct about this?

**James Walker, Chief Health Information Officer, Geisinger**

I think that is right. And more generally, sort of care goals in terms of a patient's care plan.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Yes. I do think that SNOMED CT is appropriate for this given our desire with parsimony and the fact that SNOMED CT does incorporate concepts from major nursing terminologies and classifications.

**James Walker, Chief Health Information Officer, Geisinger**

Can we have other people state whether this is obvious or that there may be things that we should look at carefully?

**Stan Huff, Intermountain Healthcare**

What I wonder about is where the thing you are looking for is the quantitative measure, like, hemoglobin AC no less than seven. Anything where it's a measurement with a threshold whether that shouldn't be stated rather than implying codes exist in SNOMED or some other terminology that are pre-coordinated or the exact thing you're looking for, whether it can be stated as a combination of a LOINC code with a cut-off level for that item.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Maybe we do need more discussion and maybe a clearer description of at least for the measures they are considering right now, what care goals are.

**James Walker, Chief Health Information Officer, Geisinger**

Good point. Thank you both. Pam or Judy, what is ONC's sense of urgency here? Are the definitions of the transitions for the various interim vocabularies more time urgent or is this more time urgent?

**Pam Cipriano**

The definition of the transition is more urgent.

**James Walker, Chief Health Information Officer, Geisinger**

Okay. If anybody wants to, please do, but if there's no dissent, let's put this on the parking lot and come back to it once we have the transition is done. Does that seem reasonable?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Absolutely.

**James Walker, Chief Health Information Officer, Geisinger**

Thank you will come back to this when we're done with the transition planning. Slide 21. We are back to Jamie's set of questions. It seems to me that we are recommending now that there will be a transition

plan for ICD-9 and ICD-10, ICD-9 procedure and ICD-10 PCS, the other procedure code CPT. Were there other vocabulary now that we believe should be acceptable for some interim?

**Pam Cipriano**

Not that I know of.

**James Walker, Chief Health Information Officer, Geisinger**

That's a reasonably manageable list. I think it would be useful to think of those, identify what the elements of the transition that we need to specify. Pam made a stab at some parts, length of interim period, how long will it be acceptable to use a given vocabulary, available value sets I'm guessing, although this may not be accurate, that the length of time these are acceptable will be short enough and resources will be constrained enough that there will probably not be any new value sets designed for these acceptable vocabularies.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Are we talking about subsets here or value sets? I mean, I am looking at subset. Is there and available subset of the vocabulary that is generally is in that area and might be used for implementation or certification possibly? I'm thinking of the value set as the 40 things or the particular algorithm that describes exactly what piece of a vocabulary is valid for what to describe a numerator or denominator of a measure? Which one is meant or both?

**Unidentified Man**

Well, I think the most common usage, I know you have articulated subsets in a number of slides on this committee as a baseline definition. But I will confess that I still use value sets as you use subset as do many other people. Whereas, I call an algorithm as you call it, I call it an algorithm.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

We won't debate this issue on what we should call it, I don't care. I am assuming that for some of these measures, the denominator is where the numerator is. I am making the uninformed assumption that in some cases, you use an algorithm and in some cases, you may actually use an enumerate set. So, I just want to be sure, are we talking about enumerated sets or algorithms, or are we talking about the fact that there is a common subset of procedures or common tasks, or common whatever's? What are we talking about?

**James Walker, Chief Health Information Officer, Geisinger**

My intention would be to include both.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

That is fine as long as I know we are talking about both.

**James Walker, Chief Health Information Officer, Geisinger**

The idea would be that, if there are existing subsets or value sets or algorithms that are out there and useful either to developers or to organization reporters or to CMS managing the data coming in, that we would identify those. My guess was there wouldn't be time to develop new ones.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I appreciate the discussion about subsets and value sets, and also, I anticipate a similar discussion about the mappings that are needed but, I think there's an element of the discussion that may be missing. That is, what certification requirements could be associated with the use of both the targeted and the interim vocabularies? Because, if you put together a package of functional requirements together with cross

maps, value sets and subsets, you can have perhaps a different view of how long it will take to transition from one point to another. Versus, a situation where you don't have any of those tools at your disposal, you might say the transition period needs to be longer. Seems to me that it might be useful, and maybe we should do it in terms for each of the vocabularies, to talk about what cross maps are available and what we would recommend be in certification to make things easier for implementers both in terms of functional criteria such as the ability to use a cross map and then come back to the transition timeline discussion.

**James Walker, Chief Health Information Officer, Geisinger**

Great. So, if I could paraphrase you for Pam to get it in. Among other things, at least you're suggesting a 4<sup>th</sup> bullet would address any ways certification can support efficient transition from acceptable vocabulary to target vocabulary? Maybe you could say that more clearly for Pam?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think you said it fine. I can only say it more long-winded.

**James Walker, Chief Health Information Officer, Geisinger**

I take your point. I think at least it seems to me that you are right, the discussion from others, if we discussed the other bullets first then length of interim period might be a summation of those other factors rather than being first out of the box. So, that is perfect. Jamie suggested, I think a useful additional bullet. We want it to be minimum necessary obviously, but are there other things we need to include in these transition plans so that developers, HIT manufacturers, care delivery organizations, CMS, have as easy a time as they can during these interim periods? Any other elements of the transition plan that we need to include? Okay.

I think then the way I envision this, now go back and say were there any additional interim vocabularies that anybody identified? Were there any of those categories or concepts as we went through them that you said, nuts, we need other vocabulary to be acceptable for some interim in this case? Okay.

Pam, Judy, others, Marjorie maybe, have we run this question by an environmental scan? Have we asked vendors, developers, or CMS, if they see a need for an interim vocabulary for any of these other categories or other concepts?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

In that regard, I notice that I don't think we had ? on here didn't we?

**James Walker, Chief Health Information Officer, Geisinger**

I don't think so.

**Pam Cipriano**

It had originally been under communication, but it did not fall under the recommended list.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I meant as an interim.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

It was part of our previous discussion. I know we talked about ? as basically one of the administrative vocabularies in our discussion with the standards committee. But, it's not on the list currently.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I guess the question would again be back to the measure developers, as to whether, I don't know whether Marjorie Rollins can comment on this or not, whether ? is used to describe any of the measures that she's familiar with?

**Marjorie Rallins, AMA**

I would say not any that I am familiar with, but I do believe that there are a few that may have used some ? codes. I think in moving forward we are not using them internally for our own purposes. So, I guess that's not a concrete answer, but it depends.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

Okay. Maybe that deserves another question, since we are talking about this as an interim issue.

**James Walker, Chief Health Information Officer, Geisinger**

Okay. Betsey, would you want to make a proposal that we include it as an interim vocabulary or is there somebody, some people we can ask?

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

I wonder if the Floyd might have a sense? I don't want to include any more in the interim if we don't need them. It's just, that was one that occurred to me as potentially being in use now and maybe it is in use for something related to equipment or whatever that would eventually go to SNOMED. I don't know.

**Pam Cipriano**

There were five concepts that previously have current measures using ?. Those are communication, non-a laboratory diagnostics, encounter, intervention, and procedure. So, the recommendations you have, Floyd obviously did not include ? in his recommendation. I don't know if Beth Franklin has joined the call. Does she have any official information?

**Juliette, NQF**

Beth had to step out for a moment. I will relay that information to her and see if she has any feedback.

**Betsey Humphreys, Co-Chair, Deputy Director, National Library of Medicine**

The issue is whether we think it would be essential or potentially important to help people in the transition. If no one thinks so, I'm certainly not eager to add to the list.

**Marjorie Rallins, AMA**

I would like to check internally. My sense is that we did not, but some of that work pre-dated me coming to this area within AMA. So, I would like to check internally and get back to you.

**James Walker, Chief Health Information Officer, Geisinger**

Are there other stakeholders we ought to check with quickly? No one else who we think whose work might be impacted by a lack of ?. Okay. Marjorie, can you report back to us tomorrow?

**Marjorie Rallins, AMA**

I will be able to do that.

**James Walker, Chief Health Information Officer, Geisinger**

Pam, let's put it last on the list to work through. Marjorie will give us a read. Is Floyd on vacation?

**Pam Cipriano**

Yes, he is not available.

**James Walker, Chief Health Information Officer, Geisinger**

Maybe NQF can give us a read also. If it happens that we miss an interim vocabulary that is needed and somebody does raise it, it would be nice if we could identify that tomorrow and get it right first. If not, we can create a new transition plan when it comes up. It is not the end of the world.

We are at 218. Does that mean, Judy, we have seven minutes more?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Yes you do.

**James Walker, Chief Health Information Officer, Geisinger**

Maybe we ought to say that the team on this call did an excellent job, which I think we have and come back tomorrow with a spreadsheet that has each interim vocabulary that we need to address and then columns for length of interim period available, values, subsets, mappings, certification, implications, so that we can try to work through the last six or seven of them tomorrow.

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

I think that is a good break.

**James Walker, Chief Health Information Officer, Geisinger**

Thank you all for your work.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

See if anybody from the public wishes to comment?

**Jamie Ferguson, Chair, Vice President, Kaiser Permanente**

Thanks Jim for leading us through this.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Operator, can you see if we have any public comments?

**Operator**

We do not have any comment at this time.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Okay. Thank you everybody Talk to you tomorrow.