January 29, 2016

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Department of Health and Human Services
200 Independence Avenue, SW
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Dear Dr. DeSalvo,

In response to the recommendations from the Transitional Vocabularies Task Force, the Health Information Technology Standards Committee (HITSC) was asked to provide your office with recommendations around the continued use of transitional vocabularies as alternatives in reporting to federal quality measure programs using EHR-captured clinical data elements. This transmittal offers these recommendations, which are informed by the deliberations among the Task Force subject matter experts, and presentations from relevant stakeholders.

Background:

In 2011, the HITSC recommended[1] a set of vocabulary standards for use in clinical quality measures based on proposals from the Clinical Quality Measures Workgroup and the Vocabulary Task Force. Recommendations were based on the following foundational concepts:

- A limited number of code sets would be used for quality measures
- Some code sets may be limited to partial depth
- Future purpose-specific subsets of code sets will be needed
- Certified HIT shall be able to process all legal codes in the code set for a given concept
- Only code sets required in HIT certification would be required for meaningful use incentive payments
- End state target standards are recommended for quality measure purposes, however some code sets will require transition plans
- The recommended code sets are being recommended for quality measures only at this time, not for other EHR functions.

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[1] https://www.healthit.gov/sites/default/files/standards-certification/HITSC_CQMWG_VTF_Transmit_090911.pdf

To allow time to incorporate the recommended code sets, the HITSC approved a set of transitional vocabularies (ICD-9 CM Diagnoses, ICD-10 CM, ICD-9 CM Procedures[2], ICD-10 PCS, CPT, HCPCS) for use until one year after Meaningful Use 3 is effective as of 2011.

Charge

Should transitional vocabularies be eliminated as alternatives in reporting to federal quality measure programs using EHR-captured clinical data elements? If so, which ones and by when?

Secondary Questions

- What is the impact of retaining the transitional vocabularies on the reliability and validity of measure results?

- What are the potential costs and implementation impacts on vendors and providers? How does that compare to the current situation with vocabulary alternatives?

Assumptions

- EHR vendors and providers have a pressing need to know what approach will be taken in regards to transitional vocabularies as soon as possible to plan and program accordingly.

- Measure developers have an even more pressing need for this decision, as changes to the current approach could change measure workflows and will change large volumes of value sets, although removal could result in simplified measure development costs and testing efforts.

- Vocabulary experts agree that there are benefits to using a single code system but that there are costs to this approach including at least initially increased effort of mapping.

The Task Force presented its recommendations to the HITSC on December 10, 2015 where the following recommendations were approved.

1. We support the original intention of the HIT Standards Committee to migrate towards encoding data to primarily support evidence-based patient care, clinical decision support, and clinical workflow rather than administrative activities.

2. We also believe this coding will better support a broad array of functions, including evidence-based clinical care, clinical decision support, clinical workflows, quality measurement, research and reimbursement.

3. The federal government should choose a date in the future to transition to clinically focused data capture and away from the support of multiple code systems for a single type of data. Thus, the task force ultimately supports one mandated reporting and exchange vocabulary for each category of data.

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[2]https://www.healthit.gov/archive/?dir=archive_files/HIT%20Standards%20Committee/2011/2011-09-28.

4. Even after migration to a single terminology for clinical data, "hybrid measures" could still continue to intentionally incorporate and combine clinical and administrative terminologies (e.g., EHR data and claims reports).

   - The use of administrative data, where specified, should be deliberate.

5. It will be acceptable to use federally permitted deconstructions of other codes into SNOMED expressions. A deconstruction is defined as the representation of a complex, pre-coordinated expression with a set of simple coded statements such that when the set is interpreted as a post-coordinated expression the set renders the same meaning.

   - The use of intensional value sets should be encouraged, i.e., where the members of the set are self-defining under the SNOMED hierarchies and relationship models.

   - The use of post-coordinated SNOMED expressions should be encouraged for secondary use cases but not for primary data capture.

   - A SNOMED expression library could, in the future, support exchange of complex ideas with a single identifier (i.e., pre-coordinated expressions), but such a technical solution is not yet available in exchange standards. The CPT and ICD-11 models may also support this approach coordinated with SNOMED in the future.

6. Transitional/alternative vocabularies will continue to be used for reporting and exchange until single, data-specific terminologies are identified and incorporated into standards and programs.

Addtionally, there is a need to establish a convening process to create a strategy or roadmap that would:

- Identify for primary, point-of-care data capture, a single clinical vocabulary for each data type that meets the needs of quality measurement as well as direct patient care and real-time clinical decision support

- Identify the technology and research gaps that must be addressed to enable the consistent, accurate coding of clinical data for both patient care and secondary use

- Outline a timeline for the removal of transitional vocabularies for each data type

- Identify mapping and tool requirements needed to achieve the above timeline.

We appreciate the opportunity to provide these recommendations.

Sincerely yours,

/s/   /s/

P. Jon White

Chair, Health IT Standards Committee

John D. Halamka

Vice Chair, Health IT Standards Committee