Quality Data Model (QDM) User Group Meeting |Minutes

Meeting date | *05/23/2018 2:30 PM ET* | Meeting location|Webinar link:
https://esacinc2.webex.com/esacinc2/j.php?MTID=me8d6277dca528e02526f28ca60f9397b

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Announcements	Chana West (ESAC)	**Cooking with CQL Webinar was held on Thursday, May 31st at 4pm ET.** These sessions are generally held on the third Thursday monthly. Upcoming events can be found by going to the eCQI Resource Center events page. – Please submit CQL-related questions and/or measure examples to cql-esac@esacinc.com **Now Available: 2019 CMS QRDA I Implementation Guide for Hospital Quality Reporting, Schematron, and Sample Files here** – The 2019 CMS QRDA I HQR IG provides technical instructions for QRDA Category I reporting for eligible hospitals and critical access hospitals reporting electronic clinical quality measures for the calendar year 2019 reporting period – You can find additional QRDA-related resources, as well as current and past implementation guides, on the eCQI Resource Center QRDA page. For questions related to this guidance, the QRDA Implementation Guides or Schematrons, visit the ONC QRDA JIRA Issue Tracker.
3 Minutes	QDM 'Category' attribute for Medication, Order (QDM-101) Recap	Floyd Eisenberg (ESAC)	During the March QDM UG meeting, the UG agreed to add the "Category" attribute to the Medication, Order datatype for QDM v5.4 to allow measure developers to specify that an order was written for a particular setting. This aligns with the HL7 FHIR resource MedicationResource.category, which provides the following options: inpatient, outpatient, community. The addition will be included in a comprehensive review of new QDM 5.4 content with the MAT Change Control Board (MCCB) on 5/24/18.
3 Minutes	Assessment, Order (QDM-202) Recap	Floyd Eisenberg (ESAC)	During the March QDM UG meeting, the group decided to add Assessment, Order as a QDM datatype for v5.4. One use case for the datatype is to allow for capture of data related to a future assessment (order is stronger than a recommendation). e.g., Providers may have a care plan with an intervention for a future assessment. The addition will be included in a comprehensive review of new QDM 5.4 content with the MCCB.

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5 Minutes	QDM Datatype “Symptom” (QDM-203) Recap	Floyd Eisenberg (ESAC)	During the April QDM UG meeting, participants reviewed the current QDM definition for "Symptom" (an indication that a person has a condition or disease) as well as the suggested usage in the HL7 FHIR Condition resource: • Observation resource—use when a symptom is resolved without long-term management, tracking or when a symptom contributes to the establishment of a condition. • Condition resource—use if it is a symptom that requires long-term management, tracking or is used as proxy for a diagnosis or problem that is not yet determined. Participants felt that the FHIR resource distinction was somewhat ambiguous and preferred retaining the existing QDM definition, but agreed to include additional guidance in QDM v5.4. The additional guidance will be included in a comprehensive review of new QDM 5.4 content with the MCCB.
5 Minutes	QDM ”method” attribute (QDM-196) Recap	Floyd Eisenberg (ESAC)	During the April QDM UG meeting, participants agreed to remove the method attribute from QDM datatypes referencing "Recommended" or "Order" as the context and retain the method attribute where present for QDM datatypes referencing "Performed" as the context. Feedback from measure developers indicates that generally the method is part of the pre-coordinated concept defining the procedure, test etc. to be ordered or recommended. The removal of the attribute will be included in a comprehensive review of new QDM 5.4 content with the MCCB.
10 Minutes	QDM ”negation rationale” attribute (QDM-197) Recap	Floyd Eisenberg (ESAC)	During the April meeting, the QDM UG reviewed the negation rationale usage and agreed to retain all existing references to the attribute. With respect to lack of ability to reference negation rationale in specifically related HL7 FHIR resources, FHIR tracker items have been entered for consideration in the May 2018 FHIR STU 4.0 ballot, recommending that FHIR resources consider notDone Reason for: • DeviceUseStatement (FHIR tracker 15938) • DeviceRequest (FHIR tracker 15939) • ServiceRequest (FHIR tracker 15940) • MedicationRequest (FHIR tracker 15941)

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15 Minutes	QDM Datatype Device, Applied (QDM-198) Recap	Floyd Eisenberg (ESAC)	During the April QDM UG meeting, the group agreed to retain Device, Applied as specified and add guidance regarding options to help measure developers and implementers determine presence or usage of a device. In many situations a measure may need to account for more than one method to identify all device usage from queries to clinical data stores. Options a measure developer can use to identify presence or usage of a device include:
			• *Option 1*—To retrieve info about the procedure that uses or implants a device, developers should use the QDM datatypes:
			  ○ *Procedure, Performed*
			  ○ *Intervention, Performed*
			• *Option 2*—To address specific information about use of a specific device, developers should use: *Device, Applied,* which allows specification of classes of devices and their usage (e.g., number of hours per day a pneumatic device to limit thromboemboli development in the legs is applied directly to the patient's leg(s)).
			• Option 3—To retrieve information that a device is present:
			  ○ *Diagnosis* – to retrieve info about the presence of a device
			  ○ *Assessment, Performed* – to retrieve an observation or finding the device is in use
			Discussion:
			Paul Denning (MITRE) - Is there a "related to" attribute for Device, Applied?
			ESAC explained there is not and asked the UG if there is a need for Device, Applied Related To a procedure. None of the attendees on the call expressed a need.
			Resolution/Next Steps:
			ESAC will seek feedback from UG participants via the JIRA ticket to determine if including a *related to* attribute might have a potential use. If so, this would be considered for a future version of QDM and not v5.4.
			The QDM UG decision to retain Device, Applied as specified and add guidance regarding options to help measure developers and implementers understand the usage will be included in a comprehensive review of new QDM 5.4 content with the MCCB.

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15 Minutes	QDM attribute "supply" (QDM-199) Recap	Floyd Eisenberg (ESAC)	**Overview:**
			The UG agreed during the April meeting to:
			• Retain the supply attribute for:
			  ○ Medication, Dispense
			  ○ Medication, Order
			  ○ Substance, Order
			  ○ Medication, Discharge
			• Remove the supply attribute for:
			  ○ Medication, Active
			  ○ Medication, Administered
			  ○ Substance, Administered
			  ○ Substance, Recommended
			  ○ Immunization, Administered
			Medication, Discharge (list of medications provided to the patient to be taken after discharge) is being reconsidered for this meeting. Data elements to document that the medications indicated by the QDM category and corresponding value set should be taken by or given to the patient after being discharged from the Encounter. Rationale for this is when a patient goes home from the hospital they receive a list of meds they should be taking, some are over the counter (no order), some they have at home (no order) and some are prescriptions. Does the supply attribute make sense for Medication, Discharge?
			Discussion:
			Joe Kunisch (Memorial Hermann) – Yes, this makes sense. This is how it works when a patient is discharged. Particularly, with home meds where it is indicated that they continue. Would not list the supply because they are not ordering it.
			Lisa Anderson (TJC) – Uses Medication, Discharge but cannot think of a use case where they would look for supply. Usually look for discharge medication list to qualify for our measures. Do not look for supply.
			Peter Muir – Noted when trying to perform a reconciliation at hospital discharge, it is extremely helpful to have what was listed. At discharge summary benefit to have discharge order in this. Difficult to go multiple places for this reconciliation. If the order comes through on discharge. Ideally, the discharge summary should include any orders at discharge, including quantity. The medication

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15 Minutes, Cont.	QDM attribute "supply" (QDM-199) Recap, Cont.	Floyd Eisenberg (ESAC), Cont.	they should be taking post-discharge will be included on a list. It is helpful if there is one place to look for this information. Ideally, the EHR reconciliation medication list will include the same fields as the facility discharge medication list to ensure interoperability. Ideally, the discharge medication list includes anything ordered with order details and what is expected to continue. ESAC noted for feasibility, developers would need to consider how often the supply detail is present in the list. Leaving the attribute makes sense, but measure developers need to consider if the implementation supports this level of detail when looking, for example, for discharge with 'no more than' or 'at least' a certain supply. Peter Muir - Leave supply attribute under Medication, Discharge and ideally the facility software should be able to have this information echoed over. Joe Kunisch (Memorial Herman) – If continuing a home med, it is unlikely this level of detail is completed. If not placing an order, the quantity will not be there. Jill Shuemaker (VCU Health) – The systems are configured differently and when pulling data electronically and looking at discharge summary many times you do not pick up the RxNorm associated with it if not attached to an order. **Next Steps/Resolution:** QDM User Group re-confirmed the decision to remove the "supply" attribute from QDM datatypes for which clinical data does not provide supply information – Medication, Active; Medication, Administered; Substance, Administered; Substance Recommended; and Immunization, Administered. QDM 5.4 retains the "supply" attribute for Medication, Dispensed; Medication, Order; Substance, Order; and Medication, Discharge. QDM v5.4 should also include guidance specific to *Medication, Discharge* and *supply* to indicate that measure developers should carefully consider feasibility when they test their measures to ensure you can find these elements.
15 Minutes	Attribute "anatomical approach site" (QDM-200)	Floyd Eisenberg (ESAC)	Source information was identified from April 2013, which addressed the original use cases for the attribute *anatomical approach site*. These are below, differentiating approach site for: • Urinary catheter insertion: suprapubic vs. urethral. • Dental sealant placement The first use case can be stated without using anatomical approach site by using procedure codes that specify urethral catheter placement, which identifies how it is put in or by using the physical object and an anatomical location.

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15 Minutes, Cont.	Attribute “anatomical approach site” (QDM-200), Cont.	Floyd Eisenberg (ESAC), Cont.	The User Group discussed the options of using: • Pre-coordinated terms from existing code systems to identify anatomical approach site information. That is the method currently used by measure developers. i.e., the name of the procedure includes the method, anatomical location and approach site information in one 'code'. • Post-coordinated terms from existing code systems. There was some discussion that post-coordination may be preferable, i.e., identifying the anatomical location and the procedure separately. In the use case of the urethral catheter, post-coordination efforts could use the physical object code for 'urethral catheter' and the procedure code for 'urinary catheterization' to cover the concern **Discussion:** Lisa Anderson (TJC) – Suggested need to keep in mind that CIMI is not pre-coordinating body site location with other things. There is variability in the field, but for quality measurement should keep at more granular level. We should not design with highly pre-coordinated fashion as it makes it difficult to reuse later. Need to develop an approach for going forward. ESAC agreed and noted anatomic location already exists in QDM to indicate placement of a catheter into a specific anatomical site defines without pre-coordination. Do we still need anatomical approach site as opposed to using anatomical location? Overall, the group could decide to add general guidance about stating in the data model that the proper clinical approach should be followed. Lisa Anderson (TJC) – This likely needs to be addressed in the governance structure, which would inform the QDM UG. Did not know of a current use case for anatomical approach site. Rob McClure (NLM Contractor) – Could not think of a use case where this attribute is critical. Recommended removing. Makes sense to assume it is pre-coordinated concept because real systems will not want to include these detailed nuances as it requires all of the elements to be completed. Any time there are differences in clinical care where the only difference is the approach site is it reasonable to expect a pre-coordinated concept to differentiate. **Next Steps/Resolution:** There was no support for continuing to include the attribute, "anatomical approach site", in QDM 5.4. It has never been used to-date in CMS program measures.

Time	Item	Presenter	Discussion/Options/Decisions
15 Minutes, Cont.	Attribute “anatomical approach site” (QDM-200), Cont.	Floyd Eisenberg (ESAC), Cont.	The QDM User Group approved removal of the attribute "anatomical approach site" in QDM 5.4 The removal of the attribute will be included in a comprehensive review of new QDM 5.4 content with the MCCB.
15 Minutes	QDM Intervention and Procedure Categories (QDM-201)	Floyd Eisenberg (ESAC)	**Overview:** The QDM categories Procedure and Intervention modeling is identical (both in CDA templates and FHIR retrieves), although defined differently: • *Intervention*—a course of action intended to achieve a result in the care of person with health problem that does not involve direct physical contact with a patient. Example: education, pneumatic device on leg. • *Procedure*—an act whose immediate and primary outcome is the alteration of the physical condition of the subject. During the April UG meeting agreed during the last meeting to retain both as it enhances the understanding of the human readable eCQM for clinician—there is a clinical distinction even though the boundary between intervention and procedure may not always be clear. Guidance will be added to the QDM v5.4 for measure developers and implementers. **Resolution/Next Steps:** This content will be included in a comprehensive review of new QDM 5.4 content with the MCCB.
15 Minutes	QDM Communication Datatype (QDM-204)	Floyd Eisenberg (ESAC)	**Overview** During the April QDM UG meeting, discussions started about whether to consolidate the QDM Communication datatype into a single datatype (*Communication, Performed*) or retain the existing three (*Communication: from Patient to Provider; Communication: From Provider to Patient; and Communication: From Provider to Provider*). The issue was brought to the current meeting for additional discussion and final decision for QDM v5.4. Communication use cases include: • A reminder or alert delivered to a provider • A recorded notification from the nurse that a patient’s temperature exceeds a value. • A notification to a public health agency of a patient presenting with a communicable disease reportable to the public health agency

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15 Minutes, Cont.	QDM Communication Datatype (QDM-204), Cont.	Floyd Eisenberg (ESAC), Cont.	• Patient educational material sent by a provider to a patient • Non-patient specific communication use cases may include: • A nurse call from a hall bathroom • Advisory for battery service from a pump The HL7 FHIR Procedure Resource indicates that the boundary between determining whether an action is a Procedure (training or counseling) as opposed to a Communication is based on whether there's a specific intent to change the mind-set of the patient. • Communication—Mere disclosure of information • Procedure—A process that involves verification of the patient's comprehension or to change the patient's mental state ESAC proposed merging these three communication datatypes into one *Communication, Performed* datatype with the following attributes: • Category – type of message • Medium – what kind of communication is allowable • Reason • Sender • Recipient • Negation rationale • Relevant period • RelatedTo • Id **Discussion:** Joe Kunisch (Memorial Hermann) – Does not see any issues with this change, but will defer to measure developers. Rob McClure (NLM Contractor) – Agreed with one datatype. Presumably need a way to indicate provider to patient, etc., in the context of creating a quality measure. ESAC agreed the measure developer will need to use terminology to identify sender and receiver so that this is more explicit for the implementer. This puts the onerous of indicating who is sending and who is receiving for the measure developer to be more explicit in the measure. Juliet Rubini (Mathematica) – It sounds like we would need to identify a SNOMED code to

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15 Minutes, Cont.	QDM Communication Datatype (QDM-204), Cont.	Floyd Eisenberg (ESAC), Cont.	represent patient and provider. Do we know how these are implemented today? Will implementer recognize the code and understand what we are trying to say? ESAC confirmed these codes currently exist in SNOMED. Juliet Rubini (Mathematica) - Do we know if these codes are being used in implementations? Rob McClure suggested measure developers will continue to use value sets and a quality measures to communicate to implementers what we expect. He noted there are large numbers of concepts in SNOMED to represent persons. This allows measure developers to be specific (e.g., only the kinds of providers looking for to provide communication). ESAC agreed implementers will need to interpret for their local use but suggested using *Communication, Performed* is clearer and less implicit than the provider to provider method as it allows more specificity. This method allows the measure developer to specify that for example, they are looking for two different kinds of providers (e.g., primary care doctor and specialists). Rob McClure (NLM Contractor) – Noted this method also allows measure developers to specify the medium (e.g., follow-up via telephone calls). Anne Smith (NCQA) – Does not use in their measures. Suggested mostly PCPI uses this. Lisa Anderson (TJC) – TJC currently uses the communication datatype in measures looking for education and will no longer use communication for that use case based upon today's clarification. ESAC noted that there have been separate discussions with PCPI team. ESAC also noted a potential use for communication in structural measures. For example, if you want to know if the provider is communicating with an immunization registry, is there a send/receive from the registry? The EHR would know about those transactions. If you wanted to create a structural measure to ensure the process is happening. Communication would fit as a datatype for that processes. For this reason, would not eliminate it. The group noted the communication datatype is currently being used 6 eCQMs. Some measure developers noted that they either stopped using the communication QDM datatypes in the CMS program 2019 reporting year measures or they intend to convert their measures in subsequent updates based on the discussions in the QDM User Group. Those measure developers continuing to use the Communication datatype(s) will need to update their measures to comply with the change to a single QDM datatype in QDM 5.4.

Time	Item	Presenter	Discussion/Options/Decisions
15 Minutes, Cont.	QDM Communication Datatype (QDM-204), Cont.	Floyd Eisenberg (ESAC), Cont.	**Resolution/Next Steps:** The QDM UG approved the change to a single QDM datatype for the QDM category, *Communication*. The rationale is that the new datatype, *Communication, Performed*, allows greater expressivity by including details about the 'sender' and the 'recipient' of the communication. This change will be included in a comprehensive review of new QDM 5.4 content with the MCCB.
5 Minutes	HL7 QI Core – QDM mapping update	Floyd Eisenberg (ESAC)	– QI Core ballot reconciliation has been completed and QI Core STU 3.0 will soon be published – Updated QDM to QI Core mapping available at: http://wiki.hl7.org/index.php?title=Harmonization_of_Health_Quality_Information_models
2 Minutes	Next Meeting	Chana West (ESAC)	**Agenda items for next QDM user group meeting** – Contact us at qdm@esacinc.com – Or start a discussion: qdm-user-group-list@esacinc.com *If you attend the QDM User Group meetings but do not receive communications or have access to the QDM User Group List, please send an email to QDM@esacinc.com so you may be added to the distribution list.* **Next user group meeting**: June 20, 2018 2:30pm – 4:30 PM ET

Invitees/Attendees:

	Name	Organization
X	Abrar Salam	The Joint Commission
	Alex Lui	Epic
	Angela Flanagan	Lantana
	Ann Philips	NCQA
	Anna Bentler	The Joint Commission
	Anne Coultas	McKesson
X	Anne Smith	NCQA
	Balu Balasubramanyam	MITRE
	Ben Hamlin	NCQA
	Beth Bostrom	AMA
	Brian Blaufeux	Northern Westchester Hospital
	Bryn Rhodes	ESAC
X	Chana West	ESAC
	Chandra Bartleman	Telligen
	Chris Moesel	MITRE
	Cindy Lamb	Telligen
X	Claudia Hall	Mathematica
X	Corrie Dowell	BSW Health
	Cynthia Barton	Lantana
	Dalana Ostile	Providence Health Systems
	Dave Wade	Apprio
X	Debbie Hall	University of Maryland
	Deidre Sacra	McKesson
	Doug Goldstein	Epic
X	Floyd Eisenberg	ESAC
	Ganesh Shanmugam	Glenwood Systems
	Howard Bregman	Epic
	James Bradley	MITRE
	Jamie Lehner	PCPI
	Jana Malinowski	Cerner
	Jean Fajen	Telligen
	Jenny Brush	ESAC
	Jenna Williams-Bader	NCQA
X	Jill Shuemaker	VCU Health
	John Carroll	The Joint Commission
	John Lujan	Kaiser Permanente
	Jessica Smails	Caradigm
X	Joseph Kunisch	Memorial Hermann
	Jorge Belmonte	PCPI
	Julie Koscuiszka	Nyack Hospital
X	Juliet Rubini	Mathematica
	Justin Schirle	Epic
	Jay Frails	Meditech
X	Kari Snyder	unknown
	Kendra Hanley	HSAG
	Kimberly Smuk	HSAG
	KP Sethi	Lantana
	Latasha Archer	NCQA

	Name	Organization
	Laura Pearlman	Midwest Center for Women's Healthcare
	Laurie Wissell	Allscripts
X	Lisa Anderson	The Joint Commission
X	Lizzie Charboneau	MITRE
X	Lynn Perrine	Lantana
	Marc Hadley	MITRE
	Marc Overhage	Cerner
	Margaret Dobson	Zepf Center
X	Marilyn Parenzan	The Joint Commission
	Martha Radford	NYU
	Melissa Van Fleet	Alliance Health Oklahoma
	Michelle Dardis	The Joint Commission
X	Michelle Hinterberg	MediSolv
	Mike Shoemaker	Telligen
	Mukesh Allu	Epic
	Neelam Zafar	The Joint Commission
	Pamela Mahan-Rudolph	Memorial Hermann
	Patty McKay	FMQAI
X	Paul Denning	MITRE
X	Peter Muir	ESAC
	Rachel Buchanan	Oregon Urology
	Rayna Scott	PCPI
X	Rebeccah Baer	NCQA
X	Rob McClure	NLM Contractor
	Rob Samples	ESAC
	Rose Almonte	MITRE
	Rukma Joshi	ESAC
	Rute Martins	MITRE
	Ruth Gatiba	Battelle
X	Ryan Clark	NCQA
	Ryan Sullivan	NYU
	Samuel Benton	NCQA
	Sethuraman Ramanan	Cognizant
X	Stan Rankins	Telligen
	Susan Wisnieski	Meditech
	Sweta Ladwa	ESAC
	Syed Zeeshan	eDaptive Systems
	Tammy Kuschel	McKesson
X	Theresa M. Jasset	Unknown
	Tom Dunn	Telligen
	Vaspaan Patel	NCQA
	Wendy Wise	Lantana
X	Yan Heras	ESAC
X	Yanyan Hu	The Joint Commission
	Yvette Apura	PCPI
X	Zach Gilman	Unknown
	Zach May	ESAC
	Zahid Butt	MediSolv