Quality Data Model (QDM) User Group Meeting |Minutes

Meeting date | *09/26/2018 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, September 27th 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
			• **QDM v5.4 has been published and contains these changes:**
			  ○ Updates to address errata: inadvertent inclusions in attribute table – Laboratory Test, Order and Laboratory Test, Recommended removed from status attribute
			  ○ Adds the attribute daysSupplied for Medication, Order; Medication, Dispensed; and Medication, Discharge
			  ○ Adds the attribute prescriberIdentifier to Medication, Order and Medication, Dispensed
			  ○ Adds the attribute dispenserIdentifier to Medication, Dispensed
			• **2019 Eligible Clinician Electronic Clinical Quality Measure Flows are available on the eCQI Resource Center as an additional resource when implementing eCQMs** and should not be used in place of the eCQM specification or for reporting purposes. Relevant for the following programs:
			  ○ Quality Payment Program (QPP): Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs)
			  ○ Comprehensive Primary Care Plus (CPC+)
			  ○ Medicare and Medicaid Promoting Interoperability (PI) programs

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes, Cont.	Announcements, Cont.	Chana West, Cont.	• **CMS published updates to eCQM value sets for 2019 reporting and performance periods to align with the most recent releases to terminologies (refer to NLM VSAC).** This addendum impacts the electronic reporting of eCQMs for the following programs: ○ QPP: MIPS and Advanced APMs ○ CPC+ ○ CMS Hospital Inpatient Quality Reporting ○ PI programs
20 Minutes	Procedure Performed (QDM-210)	Floyd Eisenberg (ESAC)	The Procedure Performed Template used for eCQM reporting in QRDA uses the start and end times for a procedure as defined in QDM to specify that the procedure has been completed. The template implies that the procedure can be counted as successfully accomplishing the intended outcome. For example, the tumor was removed, the image was obtained, or the colonoscopy successfully evaluated the patient for colon cancer. However, an end time does not always imply a successful outcome. For example, a colonoscopy might be stopped early due to incomplete preparation. This could also be true of lab test. A lab test might be completed, but the result could be 'no specimen received'. While the JIRA ticket addressed Procedure, Performed, the concern is that any completed action may not have been sufficiently adequate to indicate the action met its intended objective. Since its conception, the Procedure, Performed template in QRDA fixes the *statusCode* as "completed." If a measure developer chose to specify that an incomplete procedure should be excluded, the eCQM would need to specifically include the QDM *status* attribute for the procedure and exclude procedures with status attribute of "incomplete." Without such exclusion, the measure report includes any procedure that is completed, whether successful or not. As such, completed but unsuccessful procedures are including patients in numerators or excluding them, depending on the measure. Whether this is intentional or not from the measure developer perspective is unclear. Some provider organizations are using the list of patients that failed numerator criteria to perform follow up, especially with health maintenance and preventive care concepts. Such scenarios would not follow up for patients that meet numerator criteria (i.e., Procedure, Performed is "completed") but require repeat procedures due to some inadequacy of the original procedure. Claims-based measures allow use of a CPT modifier to indicate terminated procedures (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf), e.g.,: • Modifier 73: "surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced or the procedure initiated"

Time	Item	Presenter	Discussion/Options/Decisions
20 Minutes, Cont.	Procedure Performed, Cont. (QDM-210)	Floyd Eisenberg (ESAC), Cont.	• Modifier 74: "a medical complication arises which causes the procedure to be terminated after anesthesia has been induced or the procedure initiated" • Modifier 52: "discontinued radiology procedures and other procedures that do not require anesthesia" Patients for whom claims include CPT modifiers are included as meeting criteria in eCQM reports. The question for the QDM User Group: how would one know a procedure is actually completed and met its objective (i.e., that is was not terminated prematurely)? **Discussion Summary:** The measures currently do not specify the extent to which a procedure may be adequately or successfully performed. Hence, a completed colonoscopy is included in the numerator of the colonoscopy screening measure even if that colonoscopy was not fully successful and requires a repeat procedure. Thus, a provider's performance rate based on the measure is higher than the successful health maintenance rate determined by the provider's health care organization. Further, if only the patients failing to meet numerator compliance are included in a task list to follow up, those patients with inadequate procedures will not be on that list and may not receive expected preventive care.
20 Minutes, Cont.	Procedure Performed, Cont. (QDM-210)	Floyd Eisenberg (ESAC), Cont.	– Feedback from vendors indicates that there is no clear consistent manner in which EHRs or EHR implementers handle procedures that are inadequate to reach a conclusion regarding the reason for the procedure. Measure developers have not been able to find consistent ways to determine successful / adequate procedures. – There is some ambiguity of terms in that a procedure can be completed (i.e., it has ended) and that it may provide valuable information but yet be fully successful in providing information to initiate the next step in care. Words to define the level of concern include successful, unsuccessful, partially successful, inadequate, partially adequate and adequate. However, even when a procedure is completed, further information may be necessary to determine the next step (e.g., a pathology report about a biopsy obtained). – The issue is greater than quality measurement, it is a very significant issue with respect to clinical decision support to assure that the patient receives appropriate care and preventive screening.

Time	Item	Presenter	Discussion/Options/Decisions
20 Minutes, Cont.	Procedure Performed, Cont. (QDM-210)	Floyd Eisenberg (ESAC), Cont.	– This issue is also more pervasive than affecting procedures; it affects any activity including, but not limited to laboratory tests, diagnostic studies, physical exams, assessments. A corollary issue includes how to identify that an immunization administered from a manufacturer's lot that is subsequently recalled is identified so that the patient is recalled and receives a new dose of that vaccine. – Joe Kunisch indicated that one of the abstraction-based measures for a procedure specifically excluded procedure CPT codes that include CPT modifiers indicating the procedure was inadequate. eCQMs have not excluded such codes. His organization's established a workflow to help clinicians record the required information by creating a field with structured options consistent with the CPT modifiers to help calculate the measures and to assure those patients affected had follow up. Based on User Group discussion, there may be many workflows in existing implementations but there is not necessarily consistency, nor is the structured data available. – The discussion differentiated structured data (i.e., discrete entry options) from coded data (i.e., using a specific code system), focusing mainly on how structured data may be able to assist with this issue. **Detailed Discussion:** Sasha TerMaat (Epic) - Suggested the discussion not hinge too much on 'completion.' There are examples where we would intuitively sense the procedure was completed, but a further step is needed to achieve the desired outcome. For example, an imaging scan is completed, but there is a problem with the equipment, and we are unable to determine the desired outcome from the scan. The scan must be redone to achieve the desired result. Talking about scenarios where there is a start and end to the procedure is helpful, but there is also likely another step to achieve the desired outcome. ESAC noted the scope is not limited to Procedure, but any activity performed, like imaging, which is Diagnostic Study Performed. Howard Bregman (Epic) - Two quality measures for screening, one where the numerator for colon cancer screening is "patient had a colonoscopy" and for breast cancer screening, "patient had a mammogram." To get in the numerator the mammogram and colonoscopy need to be done. There

Time	Item	Presenter	Discussion/Options/Decisions
20 Minutes, Cont.	Procedure Performed, Cont. (QDM-210)	Floyd Eisenberg (ESAC), Cont.	are cases where by the definition of done, they were done, however, the screening was inadequate and from a clinical point of view and should not be in the numerator because a repeat scan is needed. There are CPT codes to indicate that a procedure was not done to satisfaction. CPT codes might be present, but there is nothing in the measure to indicate that the procedure was done successfully. ESAC asked if CPT codes to indicate it is done, but not successful are in the same value set to show procedure was done. Howard Bregman (Epic) - Should say CPT modifier, not code. They modify the charge for the procedure so that there is an indication of status. These are not in any eCQM value set. Presence or absence of the modifier is not considered. Also, this modifier does not apply to lab results. Joe Kunisch (Memorial Hermann) - Noted the OP29 endoscopy surveillance measure which is a manually chart extracted measure, includes modifiers. Are you saying is it not available in an electronic version? Howard Bregman (Epic) - It is not clear how to do it in the QDM and suggested he is not aware of it in any current eCQMs. ESAC noted that for the standard Procedure, Performed QRDA template the procedure statusCode is set to "completed." "Completed" does not mean successfully completed. If one wanted to say, "and not those that are completed but unsuccessful," one would need to use the QDM *status* attribute of Procedure, Performed. Is the *status* attribute sufficient to indicate the desired concept? Lisa Anderson (TJC) - Noted they do not use CPT codes in their value sets so there would need to be another way to capture discretely and a different code system to codify. Joe Kunisch (Memorial Hermann) - It is possible. We set up our endoscopy charting system to capture it. We don't map any SNOMED codes, but we put in a form for reason why test needs to be redone. If present, we can exclude the patient from the population. The options do not allow "n/a" or free text in this field, rather using pre-defined answers. ESAC suggested it sounds like there is a possibility to collect this kind of data when identifying the procedure, but we will need to investigate of real-world workflow implications to capture such information, and to determine the impact. If specified in the eCQM, the QRDA report template could include the *status* attribute to indicate whether the procedure was Complete or Not complete; however, this *status* attribute is not

Time	Item	Presenter	Discussion/Options/Decisions
20 Minutes, Cont.	Procedure Performed, Cont. (QDM-210)	Floyd Eisenberg (ESAC), Cont.	sufficient to indicate successful completion. Example expression: Procedure, Performed where status:complete is false The Procedure resource in QI Core has two metadata elements that could apply: • Status - completed/not completed [but does not indicate if successfully completed] • Outcome - successful/unsuccessful/partially successful Sasha TerMaat (Epic) - Suggested it is possible to use a metadata element like outcome. Not certain the current value set is appropriate for what we are trying to capture. In our ideal scenario, what are we capturing and then start to map to that over time. Peter Muir (ESAC) - Noted that often we may get an incomplete, repeat in one year. Clinically it is important to know was it "good enough" and when does it need to be done again. Knowing when the next procedure should be scheduled is often more valuable than complete/incomplete. ESAC suggested neither attribute is sufficient as defined. Outcome is a broad term. There is some ambiguity in the terms that would be helpful to sort out on the standards side. Peter Muir (ESAC) - Is there an adequacy of the test attribute? For example, if a Pap smear is not adequate to make a call, it would be flagged as inadequate. You performed the test, and it may have been read, but it is not adequate for the purpose of the test. Note that the pathology report determines the adequacy and it is not available until some period of time after the procedure is completed. Howard Bregman (Epic) - Suggested the issue is how is adequacy documented? Right now, EHRs do not have a discrete way to document this concept. Have other vendors implemented a discrete way to document it? The big picture is for the measure community to be aware that this appears to be the current state. Provider organizations are finding it difficult because they want to be able take patients in numerator to say that their need is satisfied. The question is what to do about the significant proportion that are false positives. There is a need to identify the patients correctly for adequate follow-up. Rob McClure (NLM Contractor) - If a procedure wasn't completed, is this captured in an encoded way as opposed to a text commen? Sasha TerMaat (Epic) - Noted the group is trying to gather what other systems are doing. She suspects many are not encoded or structured. Suggested encoded is using a standard terminology

Time	Item	Presenter	Discussion/Options/Decisions
20 Minutes, Cont.	Procedure Performed, Cont. (QDM-210)	Floyd Eisenberg (ESAC), Cont.	(what is the appropriate terminology) and structured in that it could be mapped to terminology or captured in a discrete, not textual, way. Rob McClure (NLM Contractor) - Suggested he assumes the structured part is true. Does not expect consistent encoding. Sasha TerMaat (Epic) - Suggested there are some areas where it is possible to document in an encoded fashion, for example, CPT modifiers. Epic builds features for such workflow. Our investigation has shown that there are many common workflows and the indication that we are really looking at is a textual statement, test not performed. The concept is not consistently implemented across the industry. Suggested the group should consider whether this is an important concept and whether we should try to manage and express it in a way that we implement clinical decision support. Being able to share clinical decision support requires these concepts to accommodate this type of granularity. ESAC noted the issue encountered is that there are many types of workflows and the best practice is not clear. Claudia Hall (Mathematica) - Suggested the need for caution in adding potential documentation to a large field like Procedure, Performed due to the impact. The information we really need is: do they need repeat test, do they need routine follow-up, do they need expedited follow-up, or is it complete and they do not need follow-up. Howard Bregman (Epic) - Generally we don't do this in quality measures. We look at the data generated. There is an implication of what has to be done with it, but it is not part of the measure. Rob McClure (NLM Contractor) - Need to have this conversation with the right audiences. It could be initiated by this group, but it shouldn't be done with the focus of fixing QDM. Suggested this should be driven by the need already being captured in various structured ways which can be consolidated around a standard. Howard Bregman (Epic) - In general, more procedure documentation is become structured by someone filling out a form or eventually by natural language processing it will be documented discretely by some mechanism. The question is whether we use it or not. ESAC - Noted this is aimed at improving quality of care. Joe Kunisch (Memorial Hermann) - Noted the documentation exists, it is just not existing in the form we need it (e.g., in summary notes) and we could not use in a discrete way. Quality improvement is

Time	Item	Presenter	Discussion/Options/Decisions
20 Minutes, Cont.	Procedure Performed, Cont. (QDM-210)	Floyd Eisenberg (ESAC), Cont.	often times documentation improvement (e.g., redesigning workflows to capture documentation in a different method). **Resolution/Next Steps:** The QDM User Group agreed that the issue requires further discussion in a broader audience including informaticians, and practicing clinicians. The next step is to review it with the Clinical Decision Support and Clinical Quality Information Workgroups at the upcoming HL7 Workgroup Meeting in Baltimore October 1-5, 2018; as well as other HL7 Workgroups (e.g., Orders and Observations, Patient Care) to determine methods for moving forward in developing a consensus and potential solutions.
10 Minutes	QDM Immunization, Administered (QDM - 211)	Floyd Eisenberg (ESAC)	A new Jira ticket applies to QDM v5.3 and 5.4: Immunization, Administered does not have Relevant period similar to Medication, Administered, and Author dateTime is ambiguous. Immunization, Administered attributes include: • Dosage • Negation rationale • Reason • Route • Author dateTime - time of administration or time authored • Code • Id In FHIR, the immunization resource has a date, and no author dateTime. FHIR Provenance has a recorded time which is the same as author dateTime. What is it we're looking for, administered dateTime or author dateTime? QDM Immunization Administered includes an ambiguous timing definition for author dateTime (i.e., "the time of administration or author dateTime"). The ambiguity causes duplicate and confusing mapping for vendors implementing the related eCQMs. One vaccine might provide a rationale for specifying a Relevant Period for Immunization, Administered. The Ty21a Typhoid Vaccine includes three capsules, each to be taken 48 hours apart; hence, so there is a Relevant Period could apply. However, patients self-administer the oral vaccine doses and no workflow exists to capture each administration. Should this be an interval or period to accommodate this type of vaccine? The issue at hand is to consider advising:

Time	Item	Presenter	Discussion/Options/Decisions
10 Minutes, cont.	QDM Immunization, Administered (QDM - 211), cont.	Floyd Eisenberg (ESAC), cont.	– Immunization, Administered author dateTime addressed *only* administration dateTime – For instances in which immunization information is captured as patient attestation (i.e., without documented visual evidence of the immunization administration), the QDM Assessment, Performed should be used with the result attribute indicating that immunization occurred and a date of documentation (author dateTime) – For instances in which the immunization information includes administration detail and comes from a source outside the EHR, the data should be expected in the EHR immunization section/registry with an indication of the source, thus including the administration dateTime. [Note – subsequent to the QDM User Group call, feedback from implementation sites suggests that the immunization administration may be included in the Medication section of the EHR, but that the administration date (i.e., date taken) the EHR recognizes the immunization as a medication.] – For instances in which immunization information is determined by billing records, the QDM Procedure, Performed: immunization should be used with an author dateTime. QDM changes generally occur at annual intervals. A change to administered dateTime may be preferred but may need to wait until the QDM 5.4 version in May 2019. The recommendation might also consider publishing a Known Issues list for such issues between version updates. **Discussion:** Claudia Hall (Mathematica) - Agreed that clinically you are looking for administration date time, not author date time Howard Bregman (Epic) - The edge case of the typhoid vaccine might not be worth addressing. **Resolution/Next Steps:** The QDM User Group reviewed the proposal and agreed with specifying a known issue that Immunization, Administered author dateTime references only administered dateTime (consistent with FHIR Immunization resource) - regardless of whether the immunization was administered at the clinical site or elsewhere. Also, the known issue will indicate:

Time	Item	Presenter	Discussion/Options/Decisions
10 Minutes, cont.	QDM Immunization, Administered (QDM - 211), cont.	Floyd Eisenberg (ESAC), cont.	– For instances in which immunization information is captured as patient attestation (i.e., without documented visual evidence of the immunization administration), the QDM Assessment, Performed should be used with the result attribute indicating that immunization occurred and a date of documentation (author dateTime) – For instances in which immunization information is determined by billing records, the QDM Procedure, Performed: immunization should be used with an author dateTime. The group will consider adding administrationDatetime and eliminating author dateTime with the next version of the QDM in 2019.
20 Minutes	Consider QDM evaluation with respect to HL7 FHIR for testing and feasibility (QDM-206)	Floyd Eisenberg (ESAC)	Continued discussion from July 2018 QDM UG call: In the interest of interoperability, the ESAC Team considered the impact of implementing the eCQM measures in FHIR by mapping QDM to what is currently available in the FHIR Argonaut implementation. Current implementations are based on FHIR Argonaut (DSTU 2.0). ESAC briefly reviewed the QDM to FHIR Argonaut mapping document as posted on JIRA. This document outlines how QDM maps to what is currently available in an Argonaut implementation. No further recommendations resulted from the discussion. Members are encouraged to review the content of that attached document and provide comment.
2 Minutes	QI Core – QDM mapping location	Floyd Eisenberg (ESAC)	QI Core V3 publication site: http://hl7.org/fhir/us/qicore/index.html
2 Minutes	QDM Medication Class for Allergies (QDM-188)	Floyd Eisenberg (ESAC)	Deferred until October 17th
2 Minutes	Next Meeting	Chana West (ESAC)	**Agenda items for next QDM user group meeting** – Contact us at gdm@esacinc.com – Or start a discussion: gdm-user-group-list@esacinc.com **Next Meeting** – October 17, 2018 2:30pm – 4:30 PM ET

Invitees/Attendees:

	Name	Organization
	Abrar Salam	The Joint Commission
	Alex Lui	Epic
	Andy Kubilius	Unknown
X	Angela Flanagan	Lantana
	Ann Philips	NCQA
	Anna Bentler	The Joint Commission
X	Anne Coultas	McKesson
X	Anne Smith	NCQA
	Balu Balasubramanyam	MITRE
	Ben Hamlin	NCQA
X	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
	Corrie Dowell	BSW Health
	Cynthia Barton	Lantana
	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
X	Jamie Lehner	PCPI
X	Jana Malinowski	Cerner
	Jean Fajen	Telligen
	Jenny Brush	ESAC
	Jenna Williams-Bader	NCQA
	Jill Shuemaker	VCU Health
	John Carroll	The Joint Commission
	John Lujan	Kaiser Permanente
	Jessica Smails	Caradigm
X	Joseph Kunisch	Memorial Hermann
	Jorge Belmonte	PCPI
	Julia Skapik	ONC
	Julie Koscuiszka	Nyack Hospital
X	Juliet Rubini	Mathematica
	Justin Schirle	Epic
	Khadija Mohammed	ESAC
	Kendra Hanley	HSAG
X	Kathleen Pina	Unknown

	Name	Organization
	Laura Pearlman	Midwest Center for Women's Healthcare
	Laurie Wissell	Allscripts
	Lindsey Clapper	Unknown
X	Lisa Anderson	The Joint Commission
	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
X	Matt Hardman	Unknown
	Melissa Van Fleet	Alliance Health Oklahoma
X	Mia Nievera	Unknown
	Michelle Dardis	The Joint Commission
	Michelle Hinterberg	MediSolv
	Mike Shoemaker	Telligen
X	Mukesh Allu	Epic
	Neelam Zafar	The Joint Commission
X	Pamela Mahan-Rudolph	Memorial Hermann
	Paul Denning	MITRE
X	Peter Muir	ESAC
	Rachel Buchanan	Oregon Urology
	Rayna Scott	PCPI
	Rebeccah Baer	NCQA
X	Rob McClure	NLM Contractor
	Rob Samples	ESAC
	Rukma Joshi	ESAC
	Rute Martins	MITRE
	Ruth Gatiba	Battelle
	Ryan Clark	Xcenda
	Ryan Sullivan	NYU
X	Sally	Unknown
	Sam Sayer	MITRE
	Samuel Benton	NCQA
X	Sasha TerMaat	Epic
	Sethuraman Ramanan	Cognizant
X	Stan Rankins	Telligen
	Susan Wisnieski	Meditech
	Sweta Ladwa	ESAC
	Syed Zeeshan	eDaptive Systems
	Tammy Kuschel	McKesson
	Tom Dunn	Telligen
	Yan Heras	ESAC
X	Yanyan Hu	The Joint Commission
X	Yvette Apura	PCPI