Quality Data Model (QDM) User Group Meeting | Minutes

Meeting date | *01/23/2019 2:30 PM ET* | Meeting location | Webinar link:
https://esacinc2.webex.com/esacinc2/j.php?MTID=mc47f9747fe818b4cbbd93e2318ca61a2

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Announcements	Chana West (ESAC)	• **A Cooking with CQL Webinar was held on January 31st at 4:00 PM 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 to cql-esac@esacinc.com. • **CMS and The Joint Commission (TJC) have released guidance for reporting Diagnostic Study Performed results data in 2018 CMS QRDA I Reports** (found here). ○ For 2018 reporting, CMS has aligned with TJC and result data for the Diagnostic Study Performed template (V3) must be in the value element—using the element "value" inherited from its parent template Procedure Activity Observation (V2)—in order to be processed by CMS.
10 Minutes	Review QDM Known Issue: Diagnosis Attribute for Encounter (QRDA-545)	Floyd Eisenberg (ESAC)	**Overview:** Clarification re: start and end dateTime for the diagnosis attribute for Encounter datatype A QRDA JIRA ticket questioned the intent of including the diagnosis attribute date in the Encounter Performed template. QRDA asks for an effective time, but timing is not relevant. The intent of the QDM specification is that there is no dependency on timing of a diagnosis in relation to the encounter, but only that the diagnosis was addressed during the encounter. This is an issue with the QRDA templates, and not QDM, therefore a QDM known issue is not warranted. However, there is an opportunity to consider providing clarification in the QDM v5.5 specification. Proposed clarification: Coded diagnoses/problems addressed during the encounter. The diagnosis attribute is intended to capture ALL diagnosis, including principal diagnosis. *With an Encounter, Performed diagnoses, there is no dependency on timing of the diagnosis in relation to the encounter*.

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10 Minutes, Cont.	Review QDM Known Issue: Diagnosis Attribute for Encounter (QRDA-545), Cont.	Floyd Eisenberg (ESAC), Cont.	**Discussion:** Mia Nievera (TJC) - We use encounter, diagnosis in several measures and there is confusion as to why it is written this way. Suggested that the clarification will help implementers. **Resolution/Next Steps:** The UG agreed to adding this clarification in the QDM v5.5 specification. The UG also agreed that this clarification should be considered as a Known Issue for the current version of QDM (5.4).
45 Minutes	QDM Concepts to Address *performer* (Performer requestor QDM-218 - Review dataflow attributes)	Floyd Eisenberg (ESAC)	**Overview:** During the December 2018 QDM UG call there was discussion regarding providing use cases to support attribution capabilities. The discussion further suggested that the program using the measure needs to provide guidance about how attribution should be addressed. Including detailed attribution information in measure expressions could lead to requirements to create multiple program-specific versions of each eCQM. Therefore, the UG did not further address the issue of attribution. Since its initiation, QDM has addressed general attributes that apply to all QDM datatypes; these are called *dataflow* attributes. They do not currently appear in each row of the QDM datatype tables; they are referenced separated in the narrative QDM description. , measures may need to identify the provider who performed a procedure (numerator criterion) is the same provider associated with the encounter (denominator criterion). QDM includes a "source" attribute (a dataflow attribute) but it does not specify performer; rather, it specifies the informant of the information who may be a performer but is not necessarily so. The existing QDM dataflow attributes have not been used to-date in CMS program eCQMs. A list of the three dataflow attributes with annotation discussed during the QDM UG meeting is presented below: • Health Record Field: The location within an electronic record where the data should be found. ○ Note that *health record field* is very prescriptive. Any given QDM data element may be captured and stored in various ways in clinical software. Therefore, this attribute seems excessive for the purpose of the QDM. • Source: The originator of the quality data element. The source may be an individual or a device.

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45 Minutes, Cont.	QDM Concepts to Address *performer* (Performer requestor QDM-218 - Review dataflow attributes), Cont.	Floyd Eisenberg (ESAC), Cont.	○ The *source* attribute is somewhat ambiguous. It could indicate the *informant* for any given QDM data element, or it could indicate the *performer* (i.e., the person or device that acted on the activity). • Recorder: The individual or device that enters the data element into a health record field. The desired recorder also may be, but is not necessarily, the source of the data. ○ The *recorder* attribute basically refers to the *author* of record. Previous efforts to redefine QDM dataflow attributes considered changing *source* to *performer* and *informant* and to remove *health record field*; however, there was not sufficient support for such changes in prior QDM versions. ESAC noted that during the effort to map these attributes to FHIR during the QDM to HL7 QI Core mapping exercise, *health record field* did not map to anything consistent; information requested may be present in various fields and, therefore, *health record field* is too prescriptive for use in an eCQM. *Source* mapped most consistently with the FHIR "performer" metadata elements, i.e., the individual or device that is the originator of the information. Recorder (i.e., author) of a data element can be referenced by general FHIR provenance; it is specifically referenced in individual FHIR / QI Core resources primarily for Allergy/Intolerance, Adverse Event, and Diagnosis (the diagnosis resource uses the term *asserter*). ESAC asked the UG to consider whether we should re-classify QDM *dataflow* attributes, assigning them as appropriate within each QDM datatype set of attributes and eliminate ambiguity. The proposal eliminates *health record field,* changes *source* to indicate the performer (using the most appropriate term for performer as reference in FHIR resources) and limit *recorder* to Allergy/Intolerance, Adverse Event and Diagnosis (using the terms referenced in FHIR resources). ESAC offered an example of why *performer* might be helpful in existing measures: A provider referred a patient to a specialist and that specialist responded with a consult report. If the eCQM sought to assure the person receiving the request is the performer or creator of the resulting consult, the eCQM could use the *performer* attribute to indicate the two are the same. **Discussion:** Joe Kunisch (Memorial Hermann) - Asked if *performer* is being used to identify a specific provider (using NPI number) or a general title (endocrinology)? ESAC suggested this would be left to the measure developer.

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45 Minutes, Cont.	QDM Concepts to Address *performer* (Performer requestor QDM-218 - Review dataflow attributes), Cont.	Floyd Eisenberg (ESAC), Cont.	Rob McClure (NLM Contractor) - Is there a situation where this is already being done or is this something important in the context of a specific quality measure? **Discussion:** Joe Kunisch (Memorial Hermann) - Asked if *performer* is being used to identify a specific provider (using NPI number) or a general title (endocrinology)? ESAC suggested this would be left to the measure developer. Rob McClure (NLM Contractor) - Is there a situation where this is already being done or is this something important in the context of a specific quality measure? Yiscah Bracha (RTI) - This might be useful for requester. Measure CMS50 - The idea is someone issues a referral request and the patient gets in the denominator if the referral request is issued for them and in the numerator if the request is returned. The guidance indicates that the person responsible for this action is supposed to be the provider who issued the request. In the case where multiple practices share the same patients and they are all on the same EHR, the patient will show in the denominator for all of them, but the numerator depends on the action of just one. So, all others are being held accountable for the behavior of the one clinician who issued the referral order. ESAC added that a number of measures have similar explanations of the requirements in guidance, but use workarounds for the expression. The issue is one of feasibility. If data are not available, and a workaround is required, then an eCQM should not use such an attribute. If evaluation indicates the required data exist, the eCQM chould use the *performer* attribute. Rob McClure (NLM Contractor) - The originator of the request has the responsibility for tracking the response. Guidance should be given in the measure to the implementer that whatever identifier used must have the ability to reconcile the request because they will be held accountable. So if you use something that is not an individual, then all identified will be measured, must have the ability to reconcile the request in an equal way. Do not use a group identifier if it is not supported. ESAC suggested because it is an issue with implementation, perhaps we need general program guidance rather than expecting each eCQM to include this language. Yiscah Bracha (RTI) - Suggested if there is a discrepancy between guidance and specification, resolve in favor of specification which leads to communication problems. Typically, clinicians only.

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45 Minutes, Cont.	QDM Concepts to Address *performer* (Performer requestor QDM-218 - Review dataflow attributes), Cont.	Floyd Eisenberg (ESAC), Cont.	read the guidance and might not reach deeply into the specification. Suggested that aligning guidance with specifications is a good practice. ESAC suggested implementation-level guidance like this is not present in current eCQMs. If the ability to indicate requestor is valuable to a measure this might not be sufficient reason to not include in the model. Proposal: Add an attribute to address performer in place of Source and use terms that align with the representative HL7 FHIR resources. Requester • Procedure, Recommended • Procedure, Order • Laboratory Test, Recommended • Laboratory Test, Order • Diagnostic Study, Recommended • Diagnostic Study, Order • Physical Exam, Recommended • Physical Exam, Order • Assessment, Recommended • Assessment, Order Participant • Encounter, Performed Performer • Assessment, Performed • Laboratory Test, Performed • Diagnostic Study, Performed • Physical Exam, Performed • Procedure, Performed Practitioner (perhaps use *performer* and map to Immunization.practitioner since the term *practitioner* has other uses). • Immunization, Administered

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45 Minutes, Cont.	QDM Concepts to Address *performer* (Performer requestor QDM-218 - Review dataflow attributes), Cont.	Floyd Eisenberg (ESAC), Cont.	Consider removing *recorder* except for: Patient Characteristic, Adverse Event, Allergy/Intolerance and reference the concept as *asserter* for Diagnosis/Condition/Problem. Consider removing Health Record Field. These existing attributes have never been used. As discussed, add guidance regarding how to manage the perform identifiers. **Discussion:** Joe Kunisch (Memorial Hermann) - In theory, no objections to the proposed changes. Not sure about feasibility without testing. ESAC suggested including this in the next version and strongly suggest that measure developers must test before including in their measures and provide guidance for how this should be implemented. **Resolution/Next Steps:** The UG agreed to the proposal, and these changes will be proposed to the eCQM Governance Group and the MAT Change Control Board (MCCB) for the QDM v5.5 specification. The QDM User Group agreed to remove the *health record field* attribute, to change *source* to: *performer* • *Assessment, Performed* • *Laboratory Test, Performed* • *Diagnostic Study, Performed* • *Physical Exam, Performed* • *Procedure, Performed* *requester* • *Procedure, Recommended* • *Procedure, Order* • *Intervention, Recommended* • *Intervention, Order* • *Laboratory Test, Recommended* • *Laboratory Test, Order*

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45 Minutes, Cont.	QDM Concepts to Address *performer* (Performer requestor QDM-218 - Review dataflow attributes), Cont.	Floyd Eisenberg (ESAC), Cont.	• *Diagnostic Study, Recommended* • *Diagnostic Study, Order* • *Physical Exam, Recommended* • *Physical Exam, Order* • *Assessment, Recommended* • *Assessment, Order* *participant* • *Encounter, Performed* *practitioner* • *Immunization, Administered* [May need to consider _performer_ for Immunization, Administered since _practitioner_ has additional uses] The User Group noted that Medication, Order and Medication, DIspensed already include a *prescriber.id*_ and_*dispenser.id* such that performer is already addressed; similarly Communication, Performed includes_*sender* and_*recipient*. The User Group also agreed to apply *recorder* to Allergy/Intolerance and to Adverse Event, and to apply *asserter* to Diagnosis. The changes will be included in the QDM Version 5.5 Proposal.
15 Minutes	Attribution - Program Issue	Floyd Eisenberg (ESAC)	**Overview:** During the December UG meeting measure developers considered the issue of attribute one that specific programs should address. I.e., advise implementers how to apply the measures to their individual practices or organizations specific to each program. Programs need to be more specific, specifically outlining how practices or organizations should consider implementing each measure. Thus, each program has a requirement to add guidance about how each measure should be applied. **Discussion:** Anne Coultas (McKesson) - Calculation engines will have multiple ways to handle one measure. ESAC explained the original concept was to provide an attribution id so that implementers can find all members of the program (but that eCQM developers do not define the content for the attribute

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15 Minutes, Cont.	Attribution - Program Issue, Cont.	Floyd Eisenberg (ESAC), Cont.	id; that is the responsibility of the program using the eCQM. The UG did not support that capability in QDM. Therefore, implementers will continue to calculate measure results based on the guidance provided by each program. Rob McClure (NLM Contractor) - Suggested the expectation is that this is an identifier of a person or some group. When a measure uses this element there is an expectation that the measure provide guidance about how to properly apply. QDM documentation might need to include guidance. There is an expectation that measure developers say that this element is a critical part of the measure. Given that there is an expectation of matching up providers based on this attribute that means the entity covered by the identifier needs to be able to resolve the referral. When a program indicates use of the measure, there is a responsibility on part of program to provide guidance on identifiers typically used and how they apply. Anne Coultas (McKesson) - Offered an example: CMS149, cognitive assessment measure, to get into the denominator, there must be 2+ encounters. There is no mention of who those 2+ encounters have to be with in the specification. In the situation where clinicians share patients in an EHR with other clinicians, the patient could have multiple encounters, but no two with same person. Way it is written now, the patient will get in the denominator of all clinicians, even though intent is they be in no denominator. This inclusion of the attribute can help resolve that problem. Rob McClure (NLM Contractor) - Suggested this is not a QDM issue. This is an issue which should be addressed by eCQM Governance. **Resolution/Next Steps:** It is appropriate for this group to recommend including Performer id under each datatype, but anything higher level is a guidance issue and should be referred to Governance group for discussion and resolution.
15 Minutes	Procedure, Performed (QDM 210) Follow Up	Floyd Eisenberg (ESAC)	**Overview:** During the HL7 WGM in San Antonio, Texas, the Patient Care Workgroup discussed options for determining that a Procedure, Performed was successfully performed. Outcome of the HL7 discussion: Most options for indicating successful completion of a procedure require clinician judgment and attestation that the procedure was successfully performed adds documentation requirements. Moreover, the meaning of “successful” may not be consistent across providers. To be more explicit, a measure might address raw data necessary to explicitly indicate

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15 Minutes, Cont.	Procedure, Performed (QDM 210) Follow Up, Cont.	Floyd Eisenberg (ESAC), Cont.	success using a CDS rule or measure expression by inference or derivation. For example, tumor removal was successful if all margins of the biopsy samples are clear of tumor, or colonoscopy was successful if polyps are found, biopsied or explicitly absent, etc. Methods to add metadata elements for data entry (e.g., the procedure objective and document a successful outcome based on that objective) adds burden and the criteria for "success" remains subjective. Examples being created for the HL7 Standard Data Export for Quality Measures (DEQM) by the DaVinci project include a colonoscopy measure. The DaVinci project agreed to work through the use case to confirm whether the raw data exists to infer success OR whether a change is needed to Procedure resource. Those examples should be balloted in May 2019. (See HL7 FHIR Tracker 17946). Adding an attribute to QDM might not be appropriate at this time. A measure developer might consider in the expression defining what success means and use that as evidence. **Discussion:** Rob McClure (NLM Contractor) - Suggested for these kinds of situations where success is important, the best way to address is to look for the components of success and test for those. Then the measure is expected to combine that with outcome. Joe Kunisch (Memorial Hermann) - Suggested this makes sense. Not sure an outcome attribute is needed per se because some measures have a measure of success. There are already ways to identify measure of success. Putting in a concept that outcome of success might rely on a diagnostic report or procedure note that are text based rather than discrete data elements. ESAC agreed and suggested the DaVinci group looking at this will run into those challenges. The group is evaluating the real-world issues and will provide feedback. **Resolution/Next Steps:** The UG agreed to not add anything to QDM at this point. ESAC will keep the JIRA ticket open and keep the UG abreast of the DaVinci evaluation.

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30 Minutes	QDM v5.5 Review: Consider Early Release	Floyd Eisenberg (ESAC)	High-level review of QDM UG approved QDM v5.5 changes and consider early release: – Update description of Encounter, Performed *diagnosis* attribute regarding timing (QRDA-545) – Add priority to Procedure, Order; Procedure, Performed; Encounter, Order; Encounter, Performed (QDM-212)—October 17, 2018 UG Meeting – Add present on admission indicator to Encounter, Performed diagnosis (QDM-220)—December 19, 2018 UG Meeting – Add clarification of Immunization, Administered (QDM-211)—September 26, 2018 UG Meeting – Update negation rationale timing description (QDM-219)—December 19, 2018 UG Meeting – Consider adding performer attributes to QDM datatypes (QDM-218)—January 23, 2019 UG Meeting **Discussion:** Joe Kunisch (Memorial Hermann) - Suggested it would be useful to include the present on admission indicator sooner. Currently use proxy times are used to indicate this. ESAC noted these changes are for the 2021 reporting year. If there is an urgent need to incorporate any item sooner, this is a different request. ESAC asked for others feedback. Marilyn Parenzan (TJC) - It may not be feasible to include in the measure specs for 2020. ESAC explained those who create the measures and tooling would evaluate the request, and if the answer is no, it defaults to inclusion in the 2021 version. Joe Kunisch (Memorial Hermann) - Suggested if due to timing, measure developers would not be able to use even if approved for 2020, then there is no need to make the request. Claudia Hall (Mathematica) - Suggested it will be unlikely to incorporate in the current annual update. Anne Coultas (McKesson) - QDM v5.4 was already reviewed for changes and pushing out another version is likely not feasible. Favors releasing the initial version of v5.5 earlier to allow extra time to review.

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30 Minutes, Cont.	QDM v5.5 Review: Consider Early Release, Cont.	Floyd Eisenberg (ESAC), Cont.	**Resolution/Next Steps:** The UG agreed with the QDM v5.5 changes listed for early release and agreed there is no need for an urgent request for present on admission indicator.
5 Minutes	HL7 QI Core - QDM Mapping Recap	Floyd Eisenberg (ESAC)	• QI Core STU 3.2.0 publication - consistent with US Core 1.1.0 • Build site: http://build.fhir.org/ig/cqframework/qi-core/index.html o Updated QDM to QI Core mapping o Submitted to publication - for e-vote on Technical Steering Committee o Next QI Core version depend on when US Core based on FHIR R4 is completed (Sept 2019 or Feb 2020)
5 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 *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** – Regularly Scheduled Meeting – February 20, 2019 from 2:30 to 4:30 PM ET.

Invitees/Attendees:

	Name	Organization
	Abrar Salam	The Joint Commission
	Alex Lui	Epic
X	Angela Flanagan	Lantana
	Ann Philips	NCQA
	Anna Bentler	The Joint Commission
X	Anne Coultas	McKesson
	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
	Chris Moesel	MITRE
	Cindy Lamb	Telligen
X	Claudia Hall	Mathematica
	Corrie Dowell	BSW Health
	Dalana Ostile	Providence Health Systems
	Dave Wade	Apprio
	Debbie Hall	University of Maryland
	Deidre Sacra	McKesson
	Doug Goldstein	Epic
X	Floyd Eisenberg	ESAC
	Ganesh Shanmugam	Glenwood Systems
	Howard Bregman	Epic
X	Hyok-Hee Yoo	Medisolv
	James Bradley	MITRE
	Jamie Lehner	PCPI
	Jana Malinowski	Cerner
	Jean Fajen	Telligen
	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
	Julie Koscuiszka	Nyack Hospital
	Juliet Rubini	Mathematica
	Justin Schirle	Epic
X	Jay Frails	Meditech
X	Kathy Benson	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
	Lisa Anderson	The Joint Commission
	Lizzie Charboneau	MITRE
	Lynn Perrine	Lantana
	Marc Hadley	MITRE
	Marc Overhage	Cerner
	Margaret Dobson	Zepf Center
X	Mari	Unknown
X	Marilyn Parenzan	The Joint Commission
X	Martha Radford	NYU
	Melissa Van Fleet	Alliance Health Oklahoma
X	Mia Nievera	The Joint Commission
	Michelle Dardis	The Joint Commission
	Michelle Hinterberg	MediSolv
	Mike Shoemaker	Telligen
	Mukesh Allu	Epic
	Neelam Zafar	The Joint Commission
	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
	Rose Almonte	MITRE
	Ruth Gatiba	Battelle
	Ryan Clark	NCQA
	Ryan Sullivan	NYU
	Samuel Benton	NCQA
	Sethuraman Ramanan	Cognizant
	Stan Rankins	Telligen
	Susan Wisnieski	Meditech
	Syed Zeeshan	eDaptive Systems
	Tammy Kuschel	McKesson
	Tom Dunn	Telligen
	Vaspaan Patel	NCQA
	Wendy Wise	Lantana
	Yan Heras	ESAC
X	Yanyan Hu	The Joint Commission
X	Yiscah Bracha	RTI
X	Yvette Apura	PCPI
	Zach May	ESAC
	Zahid Butt	MediSolv
X	Zeeshan Pasha	Unknown