Quality Data Model (QDM) User Group Meeting | Minutes

Meeting date | *03/18/2020 2:30 PM ET* | Meeting location|Webinar
https://esacinc2.webex.com/esacinc2/j.php?MTID=maa77b55c3024db06c9403eaa75e96891

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Announcements	Jen Seeman (ESAC)	• A Cooking with CQL session will be held on March 26, 2020 • Next QDM User Group Meeting April 15, 2020
45 Minutes	Consider update to QDM 5.5 guidance rather than create a new QDM version 5.6 (QDM-247)	Floyd Eisenberg (ESAC)	**Overview:** ESAC reviewed prior QDM User Group discussions regarding QDM moving forward. Following up from the discussion on the February 19 call, ESAC had requested User Group members to indicate if there were any mission-critical QDM updates required to express measures for the next cycle. ESAC specifically asked measure developers to consider measures currently in development and concepts for outcome measures planning within the next year. ESAC received no feedback directly or on the Jira ticket QDM-247 indicating any critical issues requiring a new version. Therefore, ESAC proposed publishing a new PDF of QDM 5.5 with guidance and maintaining availability of QDM Known Issues with the same information for use by measure developers and implementers. The value of both methods to access the guidance is to assure availability of the guidance to all who might need it. ESAC walked through the following topics to get User Group consensus regarding the guidance and to provide another opportunity for measure developers to voice concerns about critical gaps in existing QDM 5.5 coverage.
	Guidance – *result dateTime* (QDM-247)		**Laboratory Test, Performed and Diagnostic Study, Performed** The QDM User Group had previously clarified the definition of *result dateTime* to be consistent with HL7's FHIR R4 version, Observation.issued, "the date and time this version of the observation was made available to providers, typically after the results have been reviewed and verified." The User Group futher clarification that *author dateTime* should only be used to reference the time for negation rationale, i.e., the time a physician enters a reason acceptable to the eCQM logic for not performing the laboratory test. **Rationale for this change:** • Feedback from an implementation site and three vendors indicates that most systems

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			reference two times for a laboratory test: the collection time of the sample and the result time that most closely aligns with 'issued' or made available. • There are cases where a health information exchange (HIE) receives the result before making it available to the clinical site, thus potentially delaying availability. However, such differences in availability result from local implementation issues. **Updated guidance** • Use result dateTime to mean "the date and time this version of the observation was made available to providers, typically after the results have been reviewed and verified" • Author dateTime should only be used to reference the time for negation rationale. **Discussion:** User Group members had no questions regarding this guidance.
	Guidance – Medication, Active (QDM-247)		**QDM Medication, Active** Relevant Period – the start and stop time for an active medication on the medication record that is given or taken over a time interval • startTime – when the medication is first known to be used (generally the time of entry on the medication list) • stopTime – Clarification: when the medication is no longer active. **Rationale for this change:** • The medication may have lapsed based on medication dispensing events but the patient may be taking it at a reduced frequency; thus, the patient remains on the medication even though it has lapsed. • Some EHRs automatically remove medications from a medication list based on a locally determined time after it has lapsed. • Without clearly matching orders from dispensing events, the actual number of remaining doses cannot be determined. • Physicians do not necessarily discontinue medications; they remove them from the active medication list during medication reconciliation. • Based on these considerations the User Group concluded that only way to address the end of the Medication, Active Relevant Period is to indicate "When the medication is no longer active." **Updated guidance** Medication, Active relevant period stop time = "when the medication is no longer active"

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			Discussion: User Group members had no questions regarding this guidance.
	Guidance – Medication, *dosage* (QDM-247)		**QDM Medication *dosage*** The current definition for QDM attribute *dosage* is: • Details of how medication is taken or is to be taken, i.e., the quantity (mg, cc, tablets) to be taken at a single administration. **Updated guidance** • This definition should read: "Details of how much medication is taken or is to be taken, i.e., the quantity (mg, cc, tablets) to be taken at a single administration." **Discussion:** User Group members had no questions regarding this guidance.
	Guidance – Medication, Order and Dispensed *relevant Period* (QDM-247)		**Medication, Order and Medication, Dispensed *relevant Period*** The current definition for Medication, Dispensed and Medication, Order *relevantPeriod* is "the validity period, i.e., the time period for which the ordered supply is authorized by the prescription authorizing the dispensing event. However, this definition is does not clearly differentiate between the time period during which the patient should be taking the medication as compared to the period of time a pharmacist may fill the existing prescription without asking for a new prescription. The HL7 QI-Core / FHIR reference for validity period is clear, "Time period for which the supply is *authorized* (i.e., after which time dispensing should not occur)." Therefore, the QDM Medication, Order and Medication, Dispensed *relevant Period* should be based on the time period during which the patient is expected to take (self-administer) the medication, and not the *validity period.* **Updated guidance** • The Medication, Dispensed and Medication, Order relevantPeriod definition should be updated to read: – "The time referenced in the dosage instruction indicating when the medication usage should start and end." **Discussion:**

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			ESAC clarified that this dosage instruction timing refers to when the patient should take what was dispensed. Rob McClure (MD Partners) suggested the guidance read "medication administration" rather than "medication usage" to make this clear. ESAC will change the definition for *relevant Period* for these two QDM datatypes to "The time referenced in the dosage instruction indicating when the medication administration should start and end." User Group members had no further questions regarding this guidance.
	Guidance – Device, Applied (QDM-247)		**Device, Applied** QDM models Device, Applied similar to a procedure indicating that a device is actively in use during the time period indicated by the measure. The definition is potentially ambiguous since placement of a device is basically a procedure and indication that a device is "in use" may be documented as an observation, a procedure indicating the type of usage, or a report from a patient or care giver that a device is used. HL7's QI-Core, US Core and FHIR further differentiate types of devices: • Implantable Device – a device that is intended to be placed in a surgically or naturally formed cavity of the human body…for a continuous period of 30 days or more.[1] Also, any active medical device which is intended to be totally or partially introduced, surgically or medically, into the human body or by medical intervention into a natural orifice, and which is intended to remain after the procedure.[2] • Non-implantable Device – not well defined except that this category represents everything other than implantable devices – Devices used by clinicians for diagnostic or treatment purposes – Patient-use, or home use devices, intended for users in any environment outside of a professional healthcare facility. This includes devices intended for use in both professional healthcare facilities and homes.[3] • A user is a patient (care recipient), caregiver, or family member that directly uses the device or provides assistance in using the device. Example from eCQMs – antithrombotic pneumatic devices designed to prevent thrombosis. • A qualified healthcare professional is a licensed or non-licensed healthcare professional with proficient skill and experience with the use of the device so that they can aid or train care recipients and caregivers to use and maintain the device. Examples include wheelchairs, glucometers, CPAP devices, etc.). Several options may provide greater clarity for expressing device placement or usage. Measure developers should work with clinicians, implementers and EHR vendors to determine which option is most consistent with clinical workflow to retrieve the information desired:

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			• QDM datatype “Procedure, Performed” should handle most use cases for the original intent of Device, Applied. The procedure might directly reference (a) placement/insertion of a device, or (b) use/manipulation of a device for which the result attribute can reference the expected outcome of such use. • QDM datatype “Assessment, Performed” may provide reference to an observation about device usage, stability and presence. • QDM datatype “Diagnosis” may reference existence of an implantable device on a problem list • QDM datatype “Device, Order” may reference an order for the device with the *requester* attribute indicating the source of the order information (e.g., requester is practitioner if ordered by the physician; the requester is patient / care partner if for patient or care giver reporting the device is in use, i.e., not initiated by an order for durable medical equipment). **Updated guidance** Use of Device, Applied should be discouraged in favor of one of the options noted above. **Discussion:** User Group members had no questions regarding this guidance. [1] US Food and Drug Administration Center for Devices and Radiological Health. Home Use Devices. https://www.fda.gov/medical-devices/home-health-and-consumer-devices/home-use-devices. Accessed 13 March 2020. [2] BSI Group. Active implantable medical devices: https://www.bsigroup.com/en-US/medical-devices/Technologies/Active-Implantable-Medical-Devices/. Accessed 13 March 2020. [3] US Food and Drug Administration Center for Devices and Radiological Health. Home Use Devices. https://www.fda.gov/medical-devices/home-health-and-consumer-devices/home-use-devices. Accessed 13 March 2020.
	Guidance – Participation *recorder* (QDM-247)		**Participation, *recorder*** • QDM added recorder to allow all QDM datatypes to reference a performer (i.e., the individual or organization that performed an activity). • However, the comparable FHIR Resource: *Coverage*, does not include a performer or recorder. FHIR’s *Coverage* represents the insurance applicable to a patient at any given time. There is no existing use case to suggest a need for a Participation recorder in QDM. **Updated guidance** Measure developers should avoid the use of the Participation *recorder* attribute.

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			Discussion: User Group members had no questions regarding this guidance.
	Guidance – Encounter, Performed *negation rationale* (QDM-247)		**Encounter, Performed *negation rationale*** • Existing QI-Core and base FHIR Encounter resources have no mechanism to express an encounter that did not occur for a reason. • No existing eCQMs use the Encounter, Performed *negation rationale* attribute. • There is no clear use case for evaluating a reason for encounters that have not occurred. • There is no known clinical documentation to support an encounter that has not occurred for a reason (other than cancelled or no-show) **Updated guidance** Measure developers should refrain from expressing eCQMs with QDM Encounter, Performed negation rationale. **Discussion:** User Group members had no questions regarding this guidance.
	Guidance – *negation rationale* (QDM-247)		**Negation Rationale** Measure developers should evaluate use cases for negation rationale (i.e., actions intentionally not performed for a valid reason). The QDM-241 Jira ticket raised a question about how often a practitioner needs to document negation rationale; i.e., is it necessary to document the reason at every visit, or can a reason documented on a prior visit be sufficient? ● Some EHRs have functionality allowed providers to document the length of time an intervention should be deferred based on medical reasons or patient preferences. ○ For example, if a patient declines an influenza vaccine at the beginning of influenza season but indicates they will think about it, the provider can defer for two months (for the codified reason of "patient refused") so that when the patient returns for follow-up, the issue can be raised again. If the patient says they don't want an influenza vaccination this season, the length of time can be set to 11 months so that when the patient returns the next influenza season, vaccination can be readdressed. If patients say they are a life-long Christian Scientist and have never received an influenza vaccine and will never accept one, the vaccine can be permanently deferred (for the codified reason of patient refused for religious reasons) and the provider need never ask again.

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			Implementers would like to use the provider designated length of time in reporting logic so that the deferral is valid during the specified timeframe (e.g. 2 months, 11 months, forever). In the final example of the patient who refused for religious reasons, this prevents the provider from harassing the patient each year and completing unnecessary documentation each year. ● Hypothetical example based on CMS 147 Preventive Care and Screening: Influenza Immunization Patient Declined Influenza Vaccination ["Communication Performed: From Patient To Provider": "Influenza Vaccination Declined"] CommunicateFluVaccinationDeclined where CommunicateFluVaccinationDeclined.authorDatetime during "Influenza Season Including August and September of the Prior Year" **Updated Guidance:** Measure developers should consider potential practitioner burden issues that might result from negation rationale requirements in eCQMs. **Discussion:** User Group members had no questions regarding this guidance.
	Guidance Decision (QDM-247)		**Resolution/Next Steps:** The User Group consensus is to retain QDM version 5.5 and not create a new QDM version 5.6. By consensus, the User Group agreed to a new publication of QDM 5.5 with additional guidance as discussed.
15 Minutes	FHIR QI-Core Vs QUICK	Floyd Eisenberg (ESAC)	**Overview:** **QI-Core** • QI-Core authoring view (formerly called QUICK logical view) ○ Allows measure authors to choose the entire profile and specify only the items specific to the measure; the rest of the elements are populated automatically (e.g., status) ○ Streamlines authoring with QI-Core using CQL ○ Output in CQL shows QI-Core authoring view; ELM show fully expressed QI-Core details

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			QUICK • Currently under exploration in HL7 as a FHIR version-neutral top-down logical data model. There is currently no clear plan for taking this model to an HL7 ballot. **Discussion:** Dave Mishler (Care Evolution) asked if measure developers will use the QUICK data model instead of FHIR to write measures. ESAC responded that measure developers are currently using QI-Core. There are no current plans to move to a QUICK FHIR version-neutral logical model. The HL7 CQI Workgroup is currently awaiting further analysis and testing by volunteers exploring such. It is too early to know if it is feasible for measure developers and implementers. The QUICK model remains experimental at this time. In contrast, the QI-Core authoring view has been balloted and is available, lessening the need for FHIR helpers because it allows measure developers to author directly from QI-Core.
5 Minutes	General Discussion	Floyd Eisenberg (ESAC)	Attendees had no further questions or discussion topics.
5 Minutes	Next Meeting	Jen Seeman (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** – April 15, 2020 from 2:30 to 4:30 PM ET.

Invitees/Attendees:

Attended	*Name*	*Organization*
N/A	Abrar Salam	The Joint Commission
N/A	Alex Borenstein	Greenway Health
N/A	Alex Lui	Epic
N/A	Andy Kubilius	The Joint Commission
X	Angela Flanagan	Lantana
N/A	Ann-Marie Dunn	Unknown
N/A	Ann Philips	NCQA
N/A	Anna Bentler	The Joint Commission
X	Anne Coultas	McKesson
N/A	Anne Smith	NCQA
N/A	Amira Elhagmusa	Battelle
N/A	Balu Balasubramanyam	MITRE
N/A	Ben Hamlin	NCQA
N/A	Benjamin Bussey	Unknown
N/A	Beth Bostrom	AMA
N/A	Brian Blaufeux	Northern Westchester Hospital
X	Brooke Villarreal	Unknown
N/A	Bryn Rhodes	ESAC
N/A	Carolyn Anderson	Primary care practice
N/A	Chana West	ESAC
N/A	Chris Moesel	MITRE
N/A	Cindy Lamb	Telligen
N/A	Claudia Hall	Mathematica
N/A	Corrie Dowell	BSW Health
N/A	Dalana Ostile	Providence Health Systems
N/A	Dawn Lane	Covenant Health
X	Dave Mishler	Care Evolution
X	David Clayman	Allscripts
N/A	Debbie Hall	University of Maryland
N/A	Deidre Sacra	McKesson
N/A	Doug Goldstein	Epic
X	Evelyn Cody	Unknown
X	Floyd Eisenberg	ESAC
N/A	Gary Rezik	QIP
N/A	Ganesh Shanmugam	Glenwood Systems
N/A	Howard Bregman	Epic
N/A	Huy	Unknown
N/A	Isbelia Briceno	Cerner
N/A	James Bradley	MITRE
X	Jamie Lehner	PCPI
N/A	Jana Malinowski	Cerner
X	Jen Seeman	ESAC
N/A	Jenna Williams-Bader	NCQA

Attended	*Name*	*Organization*
N/A	L Dejesus	Informedika
X	Lisa Anderson	NCQA
N/A	Lizzie Charboneau	MITRE
X	Lynn Perrine	Lantana
N/A	Marc Hadley	MITRE
X	Marc Hallez	The Joint Commission
N/A	Marc Overhage	Cerner
N/A	Margaret Dobson	Zepf Center
N/A	Matt Hardman	Unknown
X	Marilyn Parenzan	The Joint Commission
N/A	Martha Radford	NYU
N/A	Melissa Van Fleet	Alliance Health Oklahoma
N/A	Mia Nievera	The Joint Commission
N/A	Michael Mainridge	Unknown
X	Michael Ryan	Unknown
N/A	Michelle Dardis	Mathematica
N/A	Michelle Hinterberg	MediSolv
N/A	Mike Shoemaker	Telligen
N/A	Mukesh Allu	Epic
N/A	Nathan R	Unknown
N/A	Neelam Zafar	The Joint Commission
N/A	Norm Sirois	Unknown
N/A	Pamela Mahan-Rudolph	Memorial Hermann
X	Paul Denning	MITRE
X	Peter Muir	ESAC
N/A	Rachel Buchanan	Oregon Urology
N/A	Rayna Scott	PCPI
N/A	R Swaineng	Swaineng Associates
X	Rebeccah Baer	NCQA
X	Rinku Master	Unknown
X	Rob McClure	MD Partners
N/A	Rob Samples	ESAC
N/A	Robin Holder	Unknown
N/A	Rose Almonte	MITRE
N/A	Ruth Gatiba	Battelle
N/A	Ryan Clark	NCQA
N/A	Ryan Guifoyle	Unknown
N/A	Samuel Benton	NCQA
N/A	Sarah Sims	My Patient Insight
N/A	Sethuraman Ramanan	Cognizant
N/A	Shanna Hartman	CMS
N/A	Stan Rankins	Telligen
N/A	Susan Wisnieski	Meditech

Attended	*Name*	*Organization*
N/A	Jill Shuemaker	VCU Health
N/A	John Carroll	The Joint Commission
N/A	John Lujan	Kaiser Permanente
N/A	Jessica Smails	Caradigm
X	Joseph Kunisch	Memorial Hermann
N/A	Johanna Ward	Mathematica
N/A	Jorge Belmonte	PCPI
N/A	Julie Koscuiszka	Nyack Hospital
N/A	Juliet Rubini	Mathematica
N/A	Justin Schirle	Epic
N/A	Jay Frails	Meditech
N/A	Katie Magoulick	CMS
N/A	Kathy Carson	SemanticBits
N/A	Kimberly Smuk	HSAG
N/A	KP Sethi	Lantana
N/A	Latasha Archer	NCQA
N/A	Laura Pearlman	Midwest Center for Women's Healthcare
N/A	Laurie Wissell	Allscripts

Attended	*Name*	*Organization*
N/A	Syed Zeeshan	eDaptive Systems
N/A	Tammy Kuschel	McKesson
X	Thomas Hudson	Unknown
N/A	Tom Dunn	Telligen
X	Traci Psihas	ESAC
N/A	Vaspaan Patel	NCQA
N/A	Ward Holland	Unknown
N/A	Wendy Wise	Lantana
N/A	Yan Heras	ESAC
X	Yanyan Hu	The Joint Commission
N/A	Yiscah Bracha	RTI
X	Yvette Apura	PCPI
N/A	Zahid Butt	MediSolv
N/A	Zeeshan Pasha	Unknown
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A