# Quality Data Model (QDM) User Group Meeting | Minutes

**Meeting date | 06/16/2021 2:30 PM ET | Meeting location|Webinar [https://global.gotomeeting.com/join/980942653](https://global.gotomeeting.com/join/980942653)**

<table>
<thead>
<tr>
<th>Time</th>
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<th>Presenter</th>
<th>Discussion/Options/Decisions</th>
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</thead>
</table>
| 5 Minutes | Announcements | Jen Seeman (ESAC) | • A Cooking with CQL, QDM and FHIR session is scheduled for June 24, 2021  
• Cypress Tech Talk - June 29, 2021  
• Driving Quality in the US: How CMS Evaluates its Measure Portfolio - July 15, 2021  
• CMS-HL7 FHIR Connectathon - July 20-22, 2021  
• Next QDM User Group Meeting - August 18, 2021 |
| 30 Minutes | QDM-264 Provider Specialty | Floyd Eisenberg (ESAC) | **Overview:**  
NCQA forwarded a request from an implementer of CMS 131. The implementer wants to explore adding a provider specialty to provider characteristic. The implementer proposes that, for CMS 131, the denominator visits should only be with providers of a certain specialty. We are unable to specify specialty. We should ask QDM to add specialty to Provider Characteristic.  
CMS131v9 Diabetes: Eye Exam  
  - [CMS131v9.html](https://global.gotomeeting.com/join/980942653)  
ESAC response: QDM 5.4 included “Provider, Characteristic” as a QDM datatype with attributes:  
  - `author dateTime`  
  - `code`  
  - `id`  
To indicate the performer of an activity (e.g., encounter) the `code` attribute could have addressed ophthalmology but linking the “Provider, Characteristic” with the individual who is the `participant` in the “Encounter, Performed” was not possible directly with the CQL expression. Basically, use of any given “Provider, Characteristic” is not feasible as QDM is modeled.  
QDM 5.5 retired “Provider, Characteristic” for this reason and added new QDM Entities as a new aspect of QDM (i.e., not QDM categories, datatypes, or attributes). Based on this change, a measure developer can indicate a specific Entity or something about a specific Entity that performs any given task or procedure. Each Entity has respective attributes  
  - Patient (identifier, id)
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<th>Discussion/Options/Decisions</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Care Partner <em>(identifier, id, relationship)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Practitioner <em>(identifier, id, role, specialty, qualification)</em></td>
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<tr>
<td></td>
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<td></td>
<td>Organization <em>(identifier, id, organizationType)</em></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Location <em>(identifier, id, locationType)</em> --- added in QDM 5.6</td>
</tr>
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</table>

This new structure allows the performer of any activity (e.g., “Encounter, Performed” participant; “Procedure, Performed” performer) to be represented by a QDM Entity with specific attributes of that Entity.

The QDM Entity modeling parallels FHIR Resources for the same concepts: Patient, RelatedPerson, Practitioner, Organization, Location

QDM 5.6 Section 2.6 describes the Entities and lists the performer attributes for each of the existing QDM datatypes. An example for the use case noted above is provided in QDM 5.6 section 2.6.2, referencing a Practitioner entity as a participant in an “Encounter, Performed” and, further indicating the Practitioner specialty is “ophthalmology”:

In this example, the eCQM uses the QDM entity Practitioner and its specialty attribute to define a qualifying encounter as one performed by an ophthalmologist:

```plaintext
define "Qualifying Encounters (2)":
    
    where exists ( 
        Encounter,participant Participant
        
        where Participant is "Practitioner"
        
        and Participant.specialty in "Ophthalmology"
    )
```

The QDM Entity, Practitioner, is modeled in a similar way as the Practitioner resource in FHIR. FHIR differentiates Practitioner (specific characteristics of a practitioner, e.g., physician, training, accreditation) from ProviderRole (i.e., the functions a given practitioner may serve in healthcare delivery). FHIR defines specialty as an element of PractitionerRole. However, QDM combines the specialty concept as an attribute of the Practitioner Entity.

In the example shown above, the “Encounter, Performed” participant is specified as a Practitioner with a specialty in “Ophthalmology.” In this context, the terminology for the specialty, ophthalmology for QDM is the SNOMED with the Occupation hierarchy (as noted in the CMS Measures Management Blueprint). Rob McClure noted that US-Core uses the
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|      |      | National Uniform Claims Committee (NUCC) Health Care Provider taxonomy provider taxonomy (available in VSAC as 2.16.840.1.114222.4.11.1066). That taxonomy comes from the UB-04 claim form and is managed by the American Hospital Association. To change from the current SNOMED Occupation hierarchy is something that might wait for the FHIR transition. However, a decision to change from SNOMED to the Healthcare Provider Taxonomy requires a review and recommendation from the Vocabulary Task Force and Governance Group to change the CMS Measures Management Blueprint. Note that no measures have yet included the QDM Entities to address use cases similar to the one presented. The decision to do so is in the purview of the measure developer to meet measure intent. Potential issues:  
- As with CMS 131, the measure developer must determine which provider is responsible for assuring an eye examination occurs for patients with diabetes (regardless of which provider actually performs the examination) - this decision is outside the scope of QDM.  
- Some implementers have voiced concerns that clinical systems may not have the ability to differentiate practitioners by specialty; therefore, specifying a specialty requires eCQM testing to assure the desired information can be retrieved from a significant number of implementations.  

**Discussion:** ESAC asked for feedback about using QDM Entities, specifically, asking about practitioner specialty. Claudia Hall (Mathematica) noted that measure developers put forth potential inclusion of specialty requirements in a measure, and received feedback from implementers that it was not feasible because specialty may be kept in credentialing systems, and especially in academic medical centers since specialty can change frequently and may not be up to date. Howard Bregman (Epic) suggested the use of specialty is not the best method to determine the participant in an encounter or procedure because the EHR would need to be able to determine the specialty. Many eye services are only provided by ophthalmology specialists, so it may be better to look for the services provided. It is more feasible to find the CPT code of the procedure performed, recognizing the billing code may not be available if performed outside of the organization. Another complicating factor is that providers often times have more than one specialty.  

ESAC asked: What if you choose to go outside of the organization and they send information back to the primary care. Would this information include the billing code? Howard Bregman |
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</table>
| 40     | QDM-263 Adverse Reaction and Allergy/Intolerance modeling | Floyd Eisenberg (ESAC)       | **Overview:** Lisa Andersen (NCQA) brought a question to the QDM User Group. NCQA’s immunization measures allow adverse reactions to count in the numerator using the QDM “Diagnosis” datatype (i.e., “Diagnosis”: “Anaphylaxis due to Diphtheria, Tetanus or Pertussis vaccine”). The measure developers want to use the “Adverse Event” or “Allergy/Intolerance” datatypes because they align better with how the data is captured. The measure developers are seeking insight on how to model the concept using these datatypes. ESAC reviewed the current modeling as presented by NCQA:  
  
  ```json
  {"Diagnosis": "Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine"},
  AnaphylaxisTd,
  where AnaphylaxisTd.prevalencePeriod starts on or before end of "Measurement Period"
  Value set defined using SNOMED codes for diagnosis of anaphylaxis to the vaccine
  ```
  The CMS Measures Blueprint provides guidance for determining the code system for Adverse Effect/Allergy/Intolerance datatypes:  

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<th>Item</th>
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<th>Discussion/Options/Decisions</th>
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| Time                                      | Item                          | Presenter                     | (Epic) suggested it varies, but you have a better chance of this being available than the provider’s specialty. Lisa Anderson (TJC) noted the measure uses SNOMED codes for the procedure and asked if using these is feasible. Howard suggested it is more likely the CPT code will be available; the SNOMED code would likely not flow discretely. **Resolution/Next Steps:** Identifying the provider specialty presents challenges and using the billing code specific to the specialty may be more feasible. ESAC will request the Vocabulary Task Force and Governance Group review a potential change to the CMS Measures Management Blueprint to change from SNOMED to the Healthcare Provider Taxonomy. The issue is significant for QDM and FHIR-based measures; it is not specific to QDM.
Rob McClure (MD Partners) suggested that, for vaccines, the expectation is that the causative agent is a CVX code. ESAC/Rob McClure agreed to follow-up with the Vocabulary WG regarding the addition of CVX to the Blueprint.

ESAC also presents the current QDM-QI-Core Mapping for Adverse Event

<table>
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<tr>
<th>QDM Context</th>
<th>QI-Core R4</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Adverse Event</td>
<td>AdverseEvent</td>
<td></td>
</tr>
<tr>
<td>n/a</td>
<td>AdverseEvent.actuality</td>
<td>actual / potential</td>
</tr>
<tr>
<td>Attributes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>code</td>
<td>AdverseEvent.event</td>
<td>Type of the event in relation to the subject; reference SNOMED-CT event hierarchy to represent the event in an eCQM. (example: vaccine reaction)</td>
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<td></td>
</tr>
<tr>
<td>severity</td>
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**Discussion:**
Rob McClure (MD Partners) suggested it is important to understand this can be represented by adverse event findings that pack everything together (similar to the “Diagnosis: Anaphylaxis to DTP vaccine”), but other systems may record pieces of an adverse event, in particular they may separate out substance/product and the reaction. ESAC noted the measure developers are currently using diagnosis with a specific SNOMED concept (anaphylaxis due to this vaccine) which is not decomposed. If desired, one could also include a severity as an attribute of “Diagnosis” in QDM and in FHIR using condition; however, in the example provided, the condition, anaphylaxis, is severe by definition. One could also decompose it the details as “Adverse Event” or “Allergy/Intolerance”, but the challenge in QDM is that there is only 1 code attribute; thus, should the code represent the causative agent or the event itself. QDM does not include an “Adverse Event” attribute for “causative agent”; noting that FHIR does include elements for event, suspectEntity, and...
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resultingCondition.

1. Overall, how would we model this?
   a. code = event (SNOMED)
   b. severity = mild, moderate, severe (SNOMED) (if needed)
   c. **CONSIDER for QDM UG** - use CQL to reference QDM Diagnosis initiating after vaccine administration

2. Should the value set represent the causative agent (i.e., the vaccine) or the manifestation diagnosis (i.e., anaphylaxis)?
   a. One measure developer experience: the causative agent was not retrievable, now changed to the event. (reflected in QDM to QI-Core mapping, event = vaccine reaction)
   b. QDM does not have an attribute for suspectEntity.instance; requires QI-Core/FHIR
   c. QDM does not have an attribute for resultingCondition; requires QI-Core/FHIR or use QDM Condition

3. Which code system(s) are appropriate? (CVX or SNOMED?)
   a. Event – SNOMED
   b. suspectEntity.instance – immunization (CVX)
   c. resultingCondition - SNOMED

4. How do we specify severity and type of reaction or allergy?
   a. severity – mild, moderate, severe

---

ESAC also presented the current QDM to QI-Core Mapping for Allergy/Intolerance

<table>
<thead>
<tr>
<th>Attributes</th>
<th>QI-Core R4</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Code</td>
<td>AllergyIntolerance.code</td>
<td>Code for an allergy or intolerance statement (either a positive or a negated/excluded statement). This may be a code for a substance or pharmaceutical product that is considered to be responsible for the adverse reaction risk (e.g., &quot;Latex&quot;), an allergy or intolerance condition (e.g., &quot;Latex allergy&quot;), or a negated/excluded code for a specific substance or class (e.g., &quot;No latex allergy&quot;) or a general or categorical negated statement (e.g., &quot;No known allergy&quot;, &quot;No known drug allergies&quot;). <strong>Binding:</strong> US Core Common substances for allergy and intolerance documentation including refutations(npreferred) - A substance or other type of agent (e.g.</td>
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<td>AllergyIntolerance.reaction</td>
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<td>AllergyIntolerance.reaction.substance</td>
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<td>AllergyIntolerance.criticality</td>
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<td>Time</td>
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<td></td>
<td></td>
<td><strong>Discussion/Options/Decisions</strong></td>
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</table>
|      |      | **1. Overall, how would we model this?**  
|      |      | a. code = responsible agent (RxNorm – consider if ingredient) – reactionSubstance in FHIR  
|      |      | b. Severity = mild, moderate, severe (SNOMED) – reactionSeverity in FHIR  
|      |      | c. CONSIDER for QDM UG - use CQL to reference QDM Diagnosis initiating after vaccine administration – reactionManifestation in FHIR |
|      |      | **2. Should the value set represent the causative agent (i.e., the vaccine) or the manifestation diagnosis (i.e., anaphylaxis)?**  
|      |      | a. The causative agent for Allergy/Intolerance. Consistent with code in FHIR;  
|      |      | b. QDM does not have an attribute for reactionManifestation, use QDM diagnosis for the condition (anaphylaxis) |
|      |      | **3. Which code system(s) are appropriate? (CVX or SNOMED?)**  
|      |      | a. code – CVX  
|      |      | b. resultingCondition - SNOMED |
|      |      | **4. How do we specify severity and type of reaction or allergy?**  
|      |      | a. severity – mild, moderate, severe |

**Discussion:**
Howard Bregman (Epic) suggested problem list or allergy list are the most effective ways to capture a disqualifying allergy. The adverse event modeling will add little value. Our allergy section captures allergies and contraindications (to substances only, not procedures).

Regarding severity on the diagnosis, the diagnosis has a severity attribute which can be applied. Fern noted if diagnosis of anaphylaxis to the vaccine, severity level may not be necessary. Howard noted Epic has severity in its allergy records and anaphylaxis would automatically be marked as severe.

**Resolution/Next Steps:**
The measure developers will consider adding allergy intolerance to the current model. ESAC/Rob McClure to follow-up with Vocabulary WG regarding the addition of CVX to the CMS blueprint.
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<tr>
<td>15</td>
<td>Minutes</td>
<td></td>
<td><strong>Yanyan Hu</strong> (TJC) asked if the “Encounter, Performed” <em>class</em> attribute will be required for the next AU cycle for all measures. QDM 5.6 added “Encounter, Performed” <em>class</em> attribute to enable identification of telehealth visits. An implementer suggested it would be much easier if “Encounter, Performed” always included the respective <em>class</em> attribute. That request caused more careful evaluation of the existing ValueSet: ActEncounterCode required by QI-Core and US Core. The value set includes ambulatory, outpatient, inpatient acute and non-acute, and virtual. The definitions of acute versus non acute in inpatient are potentially ambiguous and the value set lacks a concept of long-term care. Additionally, description of “VR” (virtual) includes the following: “A patient encounter where the patient and the practitioner(s) are not in the same physical location. Examples include telephone conference, email exchange, robotic surgery, and televideo conference.” Whether “Encounter, Performed” <em>class</em> should be required has not been decided because the Encounter.<em>class</em> value set is not appropriate for all uses. It was noted that measure developers will begin creating measures for the next AU cycle in September, so the decision will need to be timely. Yanyan Hu asked if the Encounter.<em>class</em> value set is updated, will the codes be available in VSAC for use in the next AU cycle? Rob McClure explained that updates to HL7 content occur through UTG process. The time for this process can vary. Once published, VSAC will update from there. This process takes 20 days-one month. The US-Core wording is “Shall; other codes may be used where these codes are not suitable for classification of the encounter”, which sounds like an extensible binding. This implies the code system/value set can be updated at any time after receiving approval from the Patient Administration Workgroup that manage the Encounter resource, and the US Core project team that manages US Core-specific constraints. <strong>Resolution/Next Steps:</strong> This issue requires further discussion with stakeholders. To support the needs of measure developers, and to be consistent with what vendors have, stakeholders will present the issue to the Patient Administration WG and US Core project team to discuss updating the value set.</td>
</tr>
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</table>
| 5       | Minutes            | Traci Psihas (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  
Next user group meeting  |
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<td>August 18, 2021 from 2:30 to 4:30 PM ET</td>
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<td>The July 21 meeting is cancelled as it coincides with the CMS FHIR Connectathon.</td>
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### Invitees/Attendees:

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<tr>
<th>Attended</th>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>N/A</td>
<td>Abrar Salam</td>
<td>The Joint Commission</td>
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<tr>
<td>N/A</td>
<td>Alex Borenstein</td>
<td>Greenway Health</td>
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<td>N/A</td>
<td>Alex Lui</td>
<td>Epic</td>
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<td>N/A</td>
<td>Alyson Narveson</td>
<td>Nebraska Health Network</td>
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<tr>
<td>N/A</td>
<td>Andy Kubilius</td>
<td>The Joint Commission</td>
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<td>X</td>
<td>Angela Flanagan</td>
<td>Lantana</td>
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<tr>
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<td>Ann-Maree Dunn</td>
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<td>N/A</td>
<td>Ann Philips</td>
<td>NCQA</td>
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<tr>
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<td>X</td>
<td>Amanda Grant</td>
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<td>N/A</td>
<td>Amira Elhagmusa</td>
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<td>Benjamin Bussey</td>
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<td>Beth Bostrom</td>
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<tr>
<td>N/A</td>
<td>Brian Blaufeux</td>
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<td>Brooke Villarreal</td>
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<tr>
<td>N/A</td>
<td>Bryn Rhodes</td>
<td>ESAC</td>
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<tr>
<td>N/A</td>
<td>Carolyn Anderson</td>
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<td>Chana West</td>
<td>CDQ Solutions</td>
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<td>Claudia Hall</td>
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<td>N/A</td>
<td>Corrie Dowell</td>
<td>BSW Health</td>
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<td>Dalana Ostile</td>
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<td>ESAC</td>
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