Quality Data Model (QDM) User Group Meeting |Minutes

Meeting date | *02/15/2017 2:30 PM ET* | Meeting location|Webinar link:
https://esacinc2.webex.com/esacinc2/j.php?MTID=m44a035b19cbc63ce3310c583e0354de8

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Announcements	Chana West (ESAC)	• **Upcoming Cooking with CQL Webinar on Thursday February 16th at 4:00 P.M. EST**. ○ The upcoming session will feature open discussion from subject matter experts on the Measure Authoring Tool (MAT), show how to express measures using CQL and review prepared questions. ○ Please submit CQL-related questions to cql-esac@esacinc.com • **Clinical Quality Language (CQL) testing is underway:** ○ CMS invites electronic health record vendors to participate in testing the new CQL standard for eCQMs by providing feedback related to implementation and evaluation of measures using CQL-based standards. • Interested parties should send an email expressing interest (including vendor organization, and name and contact information for 2 staff) to cql-esac@esacinc.com.
10 Minutes	Encounter, Active (QDM-161) Follow Up	Floyd Eisenberg (ESAC)	**Encounter, Active** The QDM UG previously discussed whether to retain the datatype Encounter, Active during the December 2016 meeting, and found no real use for this datatype. The concept can easily be covered by using Encounter, Performed with no end dateTime. No one on the call reported using the datatype and there are no existing CMS eCQMs using Encounter, Active. The MAT Team found eight organizations that have measures in the MAT that used the datatype, but there was no indication of current activity and these are not measures currently in use in any CMS programs. ESAC recommended contacting these groups and if there is no use, retire the datatype in the next version of QDM (5.3). Current organizations with measures registered in the MAT that use Encounter, Active:

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10 Minutes (con't)	Encounter, Active (QDM-161) Follow Up (con't)	Floyd Eisenberg (ESAC) (con't)	– Arizona State University - Dept of Biomedical Informatics – The Infectious Disease Society of America – American Gastroenterological Association – National Committee for Quality Assurance – Caradigm – American Academy of Allergy Asthma and Immunology – Lantana Consulting Group – Vanderbilt University **Plan:** Confirm with the eight organizations using Encounter, active if removing it would be problematic. If not, retire Encounter, active.
20 Minutes	QDM 5.02 – Enabling Payer Enrollment (QDM-173)	Floyd Eisenberg (ESAC)	**QDM 5.02 – Enabling Payer Enrollment Dates (QDM-173)** Use Case: Determine continuous enrollment during the Measurement Period (i.e., all members enrolled in the plan from Jan 1 through Dec 31 of the measurement year) To determine a person's membership in an organization or a care program requires something new in QDM. In HL7 FHIR representation, the concept 'organization' represents a health plan. Definition: "Organizations can be corporations, wards, sections, clinical teams, government departments, etc. Note that code is generally a classifier of the type of organization; in many applications, codes are used to identity a particular organization (say, ward) as opposed to another of the same type - these are identifiers, not codes." [https://www.hl7.org/fhir/organization-definitions.html#Organization.type] Ben Hamlin (NCQA) noted they are looking for an attribution model to allow cohort definition for a series of patients/members for the population-level manager. They would like to apply a template that standardizes the way people are assigned to a measure. Ideally, the cohort definition includes a payer plan period. NCQA is seeking a standardized model to apply to measures. Proposed Solution: Organization Resource datatype using FHIR definition: • Organization type – corporations, wards, sections, clinical teams, government departments, etc. (https://www.hl7.org/fhir/organization-definitions.html#Organization.type) – Note, this HL7 FHIR value set is quite broad.

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20 Minutes (con't)	QDM 5.02 – Enabling Payer Enrollment (QDM-173) (con't)	Floyd Eisenberg (ESAC) (con't)	Attributes: • Participation period – participation start and stop date • Participation type – e.g., extended healthcare, health spending account, automobile, public healthcare • Organization component – e.g., PPO, HMO, other plan types within the same organization • Code • Group identifier • Plan identifier • Network – should not be limited to insured **Discussion:** Joe Kunisch (Memorial Hermann) Inquired as to whether the intent of organization type in QDM is for an eMeasure developer to use this the onus would be on the vendor or individual institution to map the organization types to a specific code to be pulled out. Ben confirmed that would be the intent. By providing a standard coding structure measure developers can limit or expand measurement to provide consistency. Hospital measures generally address this issue empirically since they are based on a specific admission with a start and stop time. Joe thought it might be challenging to drill down to this level and all institutions may not define the times the same way. For example, what one organization considers an emergency department does not align across institutions across the country. As an example, the Organization datatype could define specific treatment programs (e.g., HIV program, a program for patients with brittle diabetes, etc.). Without standardization in naming programs and organization types, data will not be consistent. Ben agreed this will require creation of clear definitions and guidance. A QDM datatype for Organization is a step in the right direction. Floyd suggested that as they work through this process they can offer input to the FHIR community to enhance definitions. Floyd asked the group if inclusion in QDM makes sense and if more investigation is needed before putting something out for testing. Ben suggested this is a good start, but perhaps disseminate the proposed terms to the community to prompt more discussion.

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20 Minutes (con't)	QDM 5.02 – Enabling Payer Enrollment (QDM-173) (con't)	Floyd Eisenberg (ESAC) (con't)	Zahid Butt (MediSolv) suggested that this is more applicable to specific ambulatory use cases. Hospital measures are encounter-based and can be easily attributed to the institution. The patient-based measures on the ambulatory side are where the attributions become an issue. This new QDM datatype could be helpful in this case. Ben agreed this request primarily applies to payer level. And while the expectation that the interconnection between inpatient and ambulatory systems, and this is a step to get ahead of this. Zahid agreed that making the attribution now is in a crude fashion. More discussion needed, as well as harmonization with FHIR. Floyd asked for feedback from vendors: How do EHR products identify patient health plan enrollment or patient centered medical home (PCMH) participation now (i.e., start and stop time for enrollment)? Zahid suggested this information is hard to find. Insurance coverage is not easily attainable except to determine the active insurance policy at the time of a visit (i.e., what organization can the provider bill for 'today's' visit. Enrollment data are not easily laid out for fee for service patients. Lisa Anderson (TJC) commented currently the payer value set (supplemental data element) is optional in QRDA. The payer value set originated with the Public Health Data Standards Consortium and it is different from the HL7 value set for organization type. For hospital measures (EH), hospital managers do not necessarily take payer into account except to differentiate between Medicare and non-Medicare in the reporting context. In the future, when payer data comes in automatically, this process could result in more accurate data capture. **Resolution/Next Steps:** The team will do more investigation speaking with FHIR group. The NCQA team will begin testing using a hand-tweaked version based on this proposal during Summer 2017. Beginning in the Fall, NCQA will reach out to vendors and plan clients to support or inform any changes. Ben's team can provide information to the MAT team along the way, and this would tentatively need to be in the MAT by December 2017 to create the measures. This testing will inform the September CQL-based HQMF and QRDA ballots in HL7. Actual reporting on such measures would likely begin no earlier than the 2019 calendar year.

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20 Minutes	QDM 5.02 – Radiation Dose and Duration Attributes (QDM-172)	Floyd Eisenberg (ESAC)	Radiation Dosage and Duration are defined as attributes of the diagnostic test:
			• Radiation Dosage
			  ○ Diagnostic Study, Order
			  ○ Diagnostic Study, Performed
			  ○ Diagnostic Study, Recommended
			  ○ Procedure, Performed
			• Radiation Duration
			  ○ Diagnostic Study, Order
			  ○ Diagnostic Study, Performed
			  ○ Diagnostic Study, Recommended
			  ○ Procedure, Order
			  ○ Procedure, Performed
			
			A comment on the FHIR QI Core ballot indicated that the current modeling for radiation dose and radiation duration is incorrect in QI Core (and by default, in QDM). Integrating the Healthcare Enterprise (IHE) profiled the workflow for collecting and reporting radiation exposure due to diagnostic imaging (routine X-ray, CT Scans, etc.). Definitions are based on DICOM standards:
			
			Radiation dose (X-ray): http://dicom.nema.org/medical/dicom/current/output/chtml/part16/chapter_A.html
			
			Radiation dose (CT scans): http://dicom.nema.org/medical/dicom/current/output/chtml/part16/sect_CTRadiationDoseSRIODTemplates.html
			
			The IHE profile lists the actors involved in the clinical workflow: Reference: http://wiki.ihe.net/index.php/Radiation_Exposure_Monitoring. The profile also reviews the data collection and aggregation workflow:

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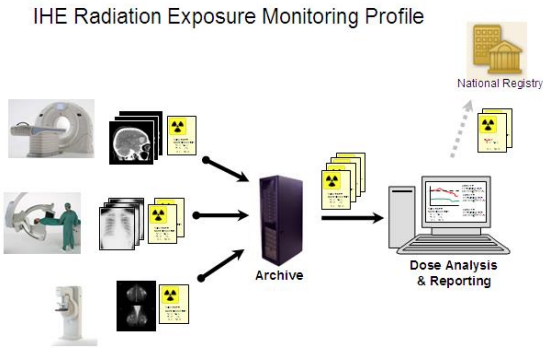
20 Minutes (con't)	QDM 5.02 – Radiation Dose and Duration Attributes (QDM-172) (con't)	Floyd Eisenberg (ESAC) (con't)	 Floyd asked the UG for their feedback regarding whether these attributes as stated still appropriate for QDM. Would it be an issue if the attributes are removed from QDM? Floyd proposed the group consider removing these attributes in the next version. **Discussion:** Zahid Butt (MediSolv) suggested the registry should try to leverage the eCQM framework rather than establish something separate. Floyd clarified the proposal is not to remove the concept completely, but rather propose an alternate way to do this, consider an assessment with components as opposed to keeping these as attributes. The QDM datatype Procedure, Performed may be a better fit and it should use a standard radiation dose analysis report and its components. **Next Steps:** Allow QDM UG members to review and discuss again on the next QDM UG call. The current plan would be to remove "radiation dose" and "radiation duration" attributes from QDM and allow Procedure, Performed to address the concern if needed in an eCQM.
20 Minutes	EHR Implementation Questions Regarding Documentation of Components	Floyd Eisenberg (ESAC)	Floyd reminded the group that components were added to QDM 5.02 for use with data types such as Assessment, Physical Exam, Laboratory Test, etc.. There was a question about the feasibility of capturing data. Feedback from vendors indicated that currently they do not capture components of exams or assessments in this manner.

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20 Minutes (con't)	EHR Implementation Questions Regarding Documentation of Components (con't)	Floyd Eisenberg (ESAC) (con't)	Current methods for capturing component information include: • Dictation • Types free text • Locally developed documentation template (e.g., Cerner's PowerNote) – may be more sensitive to clinician workflow but require additional IT staff time and effort at the implementation site • Vendor supplied documentation templates, often specific to each measure (e.g., Cerner's PowerForms) – require minimal technical work at the implementation site but not necessarily sensitive to clinician workflow Floyd asked if there was a standard way to capture components from a data collection form? If the QDM UG has any feedback regarding how to approach the feasibility of capturing components? **Discussion:** Floyd explained the component process is new and that feedback from the QDM UG vendor participants regarding feasibility would be helpful. Floyd noted in moving to direct reference codes the volume of assessment forms and components will increase. The purpose of bringing the topic to the QDM UG was to begin to identify feasibility as measures move in this direction. Joe Kunisch suggested there is no incentive for vendors to develop generic capabilities. When this becomes a requirement the vendor will build it, but typically if it is not required they will not build. **Resolution/Next Steps:** This topic will be taken offline.
20 Minutes	Direct Reference Codes Update	Floyd Eisenberg (ESAC)	A direct reference code is a single code that is not a member of a value set. The rationale for direct reference codes is that hiding a single code in a value set hides the intellectual property of the code system and creates unnecessary overhead. A single code is allowed if only one value remains and all others have been retired, or if additional concepts are forthcoming, but there is only one currently available. To accommodate direct reference codes, the new HQMF structure will require a new Terminology section, which includes the direct reference code and value set OID.

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20 Minutes (con't)	Direct Reference Codes Update (con't)	Floyd Eisenberg (ESAC) (con't)	In moving to reporting, QRDA might need to change because QRDA currently requires value set OIDs for every template and with direct reference codes, there are no OIDs. This would be a change to the next version of QRDA Category I, which has not yet been developed. In reviewing this change, a question arose about the need for OIDs universally when also submitting a code. Justification for removing the value set OID from QRDA Category I: 1. If a single instance of code exists in the EHR and it is included in 2 or more value sets referenced in a measure, the sender must submit the code for each referenced value set, hence there are a lot of duplicate results submitted. 2. If the QRDA did not require the value set OID, each instance of the code could be submitted only once. Those receiving QRDA files would need to retool and also validate that the codes received are in the required value sets using external files. Options when moving to 2019 reporting under consideration: 1) provide OID and value *OR* the direct reference code, or 2) supply the code with related metadata (but not the value set) for all data elements. **Discussion:** Paul Denning (MITRE) asked if this change applies to QDM 4.3 and QRDA Category I, Version 4. Floyd clarified this is for subsequent versions. It only applies for future measures when CQL is being used (measures written and submitted after April 2018 release). Joe Kunisch (Memorial Hermann) asked how this change might impact negation rationale. Floyd explained that providers currently send the negated value set OID without the value. Consequently for the *Not Done*, providers would still need to send the value set OID (i.e., the solution would need to assure a value from that negated value set is not required). Joe suggested this sounds reasonable. For consistency, it makes sense to send the OID when there is negation, even if just one value exists in the value set. If the data element includes a value set OID, the provider negates the OID, if the data element includes a direct value, the provider negates the value.

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20 Minutes (con't)	Direct Reference Codes Update (con't)	Floyd Eisenberg (ESAC) (con't)	Zahid Butt (MediSolv) suggested in the option where the element is done, but the OID is not provided, there will be overhead to validate the value provided. Floyd noted TJC and other systems do not use the OID to perform validation; rather, they validate based on code against value set they have from VSAC. De-duplication creates unnecessary overhead. Those that use the OID within the QRDA for validation will need to retool their processes. This is the reason the issue was brought to this group for feedback on the impact of this potential change. **Resolution/Next Steps:** The QDM UG will go back to their teams for their feedback.
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 - March 15, 2017 from 2:30 to 4:30 PM ET.

Action Items:

Assignee	Topic	Action Item Details
ESAC	Encounter Active	Confirm with the eight organizations using Encounter, active if removing it would be problematic
All Representatives	Radiation Dose and Duration Attributes	UG to review radiation dose and duration attribute and provide feedback regarding whether these attributes as stated are still appropriate for the QDM
ESAC	Enabling Payer Enrollment	Continue discussions with FHIR group, as outcomes of this (and NCQA testing) will inform September ballots
ESAC	EHR Implementation Questions Regarding Documentation of Components	Continue offline discussions regarding feasibility of documenting components within vendor systems
All Representatives	Direct Reference Codes and Considerations for removal of VS OID from QRDA reporting	Consider the pros/cons of QRDA reporting and retention vs. removal of value set OID

Attendees:

	Name	Organization
	Abby Rech	
	Alex Lui	Epic
	Amanda Hashman	
X	Angela Flanagan	Lantana
	Anna Bentler	The Joint Commission
X	Anne Coultas	McKesson
x	Anne Smith	NCQA
	Balu Balasubramanyam	MITRE
x	Ben Hamlin	NCQA
	Brian Blaufeux	Northern Westchester Hospital
	Brittni Frederksen	
	Bryn Rhodes	ESAC
	Carolin Spice	
x	Chana West	ESAC
	Chandra Bartleman	Telligen
	Chris Markle	ESAC
	Chris Moesel	MITRE
	Cindy Lamb	Telligen
	Cynthia Barton	Lantana
	Dalana Ostile	Providence Health Systems
	Dave Stumpf	
	Dave Wade	Apprio
	Debbie Hall	University of Maryland
	Flor Cheatham	
x	Floyd Eisenberg	ESAC
	Howard Bregman	Epic
	Jamie Jouza	PCPI
	Jean Fajen	Telligen
x	Jeff Pitcher	
	Jenna Williams-Bader	NCQA
	John Carroll	The Joint Commission
	Jennifer Bonner	
	Jessica Smails	
X	Joe Kunisch	Memorial Hermann
	Jorge Belmonte	AMA
	Julia Skapik	ONC
	Julie Koscuiszka	Nyack Hospital
X	Juliet Rubini	Mathematica
X	Justin Schirle	
	J Frails	Meditech
	Khadija Mohammed	ESAC

	Name	Organization
	Kendra Hanley	HSAG
x	Kimberly Smuk	HSAG
	KP Sethi	Lantana
	Latasha Archer	NCQA
	Laura Pearlman	Midwest Center for Women's Healthcare
x	Lisa Anderson	The Joint Commission
	Lizzie Charboneau	MITRE
	Lynn Perrine	Lantana
	Marc Hadley	MITRE
x	Margaret Dobson	Zepf Center
	Marilyn Parenzan	The Joint Commission
x	Michelle Dardis	The Joint Commission
	Michelle Hinterberg	MediSolv
	Mike Shoemak	Telligen
	Mukesh Allu	Epic
	Nadia Ramey	ESAC
x	Pamela Mahan-Rudolph	Memorial Hermann
	Patty McKay	FMQAI
x	Paul Denning	MITRE
	Rebecca Swain-Eng	
	Rose Almonte	MITRE
	Rob McClure	NLM Contractor
	Rukma Joshi	ESAC
	Rute Martins	MITRE
	Ruth Gatiba	Battelle
	Ryan Clark	Xcenda
	Sethuraman Ramanan	Cognizant
	Stan Rankins	Telligen
	Susan Wisnieski	Meditech
	Syed Zeeshan	eDaptive Systems
	Tammy Kuschel	McKesson
	Teresa Ansell	
	Tom Dunn	Telligen
	Toni Wing	
	Vaspaan Patel	NCQA
	Wendy Wise	Lantana
X	Yan Heras	ESAC
X	Yanyan Hu	The Joint Commission
	Yvette Apura	AMA-ASSN
X	Zahid Butt	MediSolv
	Zach May	ESAC