

Quality Data Model (QDM) User Group Meeting | AGENDA/MEETING MINUTES

Participants: Yvette Apura, Dori Bilik, Elizabeth Bostrom, Zahid Butt, Lynn Cason, Michelle Dardis, Deb Hall, Jeffrey Hammer, Sharon Hibay, Michelle Hinterberg, Jamie Jouza, Rosemary Kennedy, Joseph Kunisch, Rob McClure, Patti McKay, Chris Moesel, Balu Balasubramanyam, Gina Molla, Lauren Niles, Vaspaan Patel, Stan Rankins, Justin Schirle, Anne Smith, Dawn Stapleton, Judith Warren, Lori Welsch, Lindsey Wisham

Meeting date | 10/15/2014 2:30 PM EDT | Meeting location | Webinar video link: <https://www4.gotomeeting.com/register/303510935>

Agenda Item	Time/Presenter	Objective	Discussion/Options/Decisions	Comm*
Participants	2:30 / Balu	Welcome participants		
Sep 24th Meeting Minute Review	2:30 / Chris	Review discussion, decisions, and action items from previous meeting	Follow-up activities resulting from the last User Group Meeting were shared.	
QDM Issue Review	2:35 PM	<u>QDM-55</u> : Representing Patient location at the time of death	<p>MITRE noted that HL7 Health Service Locations value set used by HAI measures is not currently supported and not listed in the VSAC. There are 212 different codes in the value set, many of which are not likely to be applicable. The value set likely does not contain codes to express locations <i>outside</i> of the hospital, so may not be applicable to this use case (location of death). One of the participants suggested that using a smaller set of codes that a human can interpret and validate, made sense. The consensus was to use a set that was implementable.</p> <p>There was discussion regarding whether or not QDM should bind the proposed 'location' attribute to a specific value set. At this time, QDM does not have a way to bind attributes to value sets. One terminology expert suggested that this is a limitation in QDM that should be addressed at some point.</p> <p>The group discussed the pros and cons of mapping the value set codes to the concepts. The group also discussed whether or not this data would be defined well enough (and consistently) to derive real value. The group agreed that this topic likely needs a champion, with a real use case, to refine requirements and progress further.</p>	

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	3:05 PM	<u>QDM-37</u> : Fundamental problem with diagnosis datatypes	<p>This was a complex topic and created a lot of discussion. The group discussed whether <i>Condition</i> and <i>Diagnosis</i> should be different data types (<i>Condition</i> having <i>onset</i> and <i>abatement</i>, and <i>Diagnosis</i> having <i>assertion</i> and <i>active/inactive</i>). FHIR uses <i>Condition</i> as a single class with components about the condition <i>and</i> diagnosis included. One group member recalled having a similar discussion for the never-implemented QDM 3.0.</p> <p>There was discussion regarding whether QDM really needed a <i>fundamental</i> change to Diagnosis data types, and some concern that FHIR might be too “green” to use as a model to inform future QDM changes. Regarding the problem with <i>Diagnosis, Active</i>, there is confusion regarding whether it is when a condition is diagnosed, or when the condition first started – i.e., onset? The current model also doesn’t allow a <i>Diagnosis, Active</i> to be easily related to its corresponding <i>Diagnosis, Resolved</i>. Regarding “greenness” of FHIR, hopefully FHIR’s 80/20 rule gives some confidence that data is real and available.</p> <p>Other nuances were also discussed. For example, a nurse may make an observation of chest pain, which a doctor later diagnoses as a heart attack. QDM does not provide a way to talk about the former statement. One participant also expressed concern with the use of the term ‘Condition’ because, in the QUICK model, a condition may be a normal observation (not necessarily a disease, problem, etc.). One member suggested that <i>Condition</i> is a finding, not an <i>Observation</i>. The QDM team agreed to look more deeply at how <i>Condition</i> is represented in QUICK and FHIR.</p> <p>The question was raised regarding what <i>Diagnosis, Inactive</i> means. An example was given for an inflammatory bowel disease that has not <i>abated</i>, but is in remission. Also, in a clinical workflow, if a patient enters the ER with a heart attack, a nurse may <i>inactivate</i> longitudinal problems (such a gout) on the problem list—since they are not the</p>	

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			<p>main concern at the moment. This is not likely the intent of <i>Diagnosis, Active</i>, however. One participant suggested that nuances like this are not helpful and should be avoided when possible. A question was asked whether the concept of <i>inactive</i> had to be carried forward (noting that it is not modeled in QUICK). One of the participants stated <i>No</i>.</p> <p>There was continued discussion asking if moving to a single data type was a good idea, and whether there is a need for a <i>status</i> attribute (or if condition / diagnosis could be distinguished using the date attributes). One member suggested instead of <i>Diagnosis, Resolved</i>, have a single <i>Diagnosis, Active</i> datatype that had an <i>onset</i> and <i>abatement</i> date. Another member expressed concern with having 'Active' in the name, especially if a resolved diagnosis could be represented. The same member also suggested that 'Diagnosis' itself also wasn't the correct terminology for the concept.</p> <p>It was noted that QDM's <i>Symptom</i> category also contains active/inactive/resolved data types. Since nobody used <i>Symptom</i>, its possible removal was suggested.</p> <p>There were suggestions to consider FHIR-related implications before QDM move towards how <i>Condition</i> would be modeled. There were questions on how timing relationships apply if we chose a single datatype to represent it? – will they be representable, what would they mean, etc. There was also concern regarding some edge cases, such as how AMI re-admissions would be represented. This led into the topic of representing the Encounter Diagnosis, which should be considered for QDM.</p>	
	4:05	<u>QDM-94</u> : Need a better way to link related encounters	The most common use case for linking encounters is probably linking an ED encounter to the following Inpatient Encounter. Linking them with timing relationships does not work in all cases because some measures may want to treat them as a single encounter. For example,	

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			<p>if compression stockings are done in an ED encounter that later becomes an inpatient encounter; Or in the case of an elective surgery where the admit order is done after the post-op. The date time of the surgery therefore is before the date time of the encounter, and gets excluded from the measure. In some cases, however, the distinction between the linked encounters is very important. This led to discussion on whether the group should consider an 'Episode of care' framework within QDM, otherwise logic may be repeated throughout the measure.</p>	
	4:30	Conclusion	<p>Next QDM User Group meeting will be held November 19th from 2:30-4:30PM EST.</p>	
Next steps				