

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

Meeting date | 1/28/2015 2:30 PM EDT | Meeting location | Webinar video link: <https://www4.gotomeeting.com/register/303510935>

Attendees: Yvette Apura, Itara Barnes, Elizabeth Bostrom, Howard Bregman, Sasha Brellenthin, Balu Balasubramanyam, Zahid Butt, John Carroll, Yvonne Chen, Anne Coultas, Annette Edmonds, Trish Elder, Pavla Frazier, Jeffrey Geppert, Tannasia Gonzalez, Sharon Hibay, Michelle Hinterberg, Yanyan Hu, Jamie Jouza, Jane Koenig, Kate Konitzer, Joseph Kunisch, Tammy LaFavor, Jana Malinowski, Susan Mateja, Rob McClure, Patti McKay, Christopher Moesel, Ann Phillips, Stan Rankins, Juliet Rubini, Sophie Scheidlinger, Julia Skapik, Anne Smith, Carolin Spice, Dawn Stapleton, Patrick Yamaura

Agenda Item	Time/Presenter	Objective	Discussion/Options/Decisions
QDM Issue Review	2:35 PM	QDM-102: Codes for "Principal" ordinality	<p>The "Principal" value set used in measures to indicate <i>Principal</i> ordinality for diagnoses and procedures contains SNOMED code 63161005, which usually is a qualifier value in reference to time. This is not likely the most appropriate code. A user group member defined the multiple meanings of <i>principal</i>, including the legal definitions (related to billing) and the clinical concept (regarding that which was the clinicians <i>primary</i> focus). The distinction between these uses is important and should be represented by different codes and value sets.</p> <p>One of the participants noted that clinical EHRs support a way to indicate the principal (i.e., <i>primary</i>) diagnosis, but clinicians often don't use it. Currently, when a clinician doesn't specify it, it falls back to the principal billing diagnosis. If we supported the distinction (clinical vs. billing), then if a measure calls for the clinical meaning, and it's not there, does that mean we shouldn't fall back to claims data (and can that distinction really be made)? The participants confirmed that this would impact workflow, but that this is something we should be thinking about. For example, clinical decision support really needs this information (often the billing diagnosis is determined too late).</p>

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			<p>One of the participants stated that the legal definition of “principal” usually aligns well with charted measures (as the condition that brought the patient to the hospital). The IQR has always been based on the principal diagnosis code. The main problem is that the principal diagnosis code is usually identified closer to the discharge (or even after it). During the middle of the inpatient stay, the principal (billing) diagnosis is likely not yet coded.</p> <p>Another participant asked whether we know all of the possible ways that EHR's capture principal diagnosis. It would be worthwhile to do an environmental scan of the use and capture of principal diagnosis. A representative from ONC indicated that there are forums for surveying the ways that data is captured, and we could potentially use them.</p> <p>Another participant agreed with the notion that it’s important to capture the primary (non-billing) diagnosis as well. The participant referenced one vendor system that has about 15 different modifiers for flagging diagnoses (principal, primary, working, etc) – so the ability to capture the data is present.</p> <p>A representative from ONC suggested we try to come up with some approaches to this topic. Can we find out how people capture this? What information would CDS developers need? What terminology exists that would be appropriate?</p> <p>One of the participants stated that in some EHRs (in an inpatient setting), there is a check box when a physician enters a problem into the problem list in an Encounter. The checkbox indicates which problem is <i>principal</i>, but it is not a</p>

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			<p>code-able concept (i.e., SNOMED-CT) as the <i>principal diagnosis</i>. Coders usually code the principal diagnosis at discharge. So... who captures the data and where it is captured drives whether it goes into billing or not.</p> <p>Another participant stated that the definitions for <i>principal</i> may be standardized, but the reality is that it will not always be used in a standardized way. In the quality domain, it will be important for measure authors to use the correct value set / code for principal based on their intended meaning. For CDS rule authors, principal billing diagnosis is not helpful since it is usually not defined until discharge.</p> <p>After this conversation, <u>QDM-102</u> was filed to track the suggested way forward.</p>
	2:45PM	<p><u>QDM-87</u>: Ability to refer to immunizations is inconsistent with interoperability standards</p>	<p>MITRE re-introduced the issue regarding QDM's representation of immunizations using Medication data types. This representation requires a workaround in QRDA and does not align well with C-CDA and FHIR. MITRE also noted that there are ongoing discussions regarding the representation of Immunizations in FHIR, and "harmonization" with <i>MedicationAdministration</i>.</p> <p>One participant asked why Immunizations and Medications are represented as different data types in other systems. Is it just because they use different codes (RxNorm vs. CVX)? Or is there more to it? Another participant provided some background regarding how immunizations are billed differently than medications (you bill separately for the vaccine <i>and</i> the administration). The vaccine might be an RxNorm code, but the administration was always a CVX code. Now there are also global codes to represent the vaccine and administration. The first participant then suggested that the difference is contrived, and perhaps we shouldn't make any change until we have a better reason for doing so. He then indicated that the CVX code system was odd in some ways. Some codes actually tie-in where you are in the immunization</p>

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			<p>schedule (e.g., a “catch-up). Generally speaking, however, terminologists <i>tend</i> to think of CVX codes as <i>substances</i>.</p> <p>Another participant suggested that it might make sense to separate them because EHR's might store them in different tables. Another participant noted that the separation makes things easier. We <i>think</i> of medications and vaccinations as different things, so separating them might make the QRDA reporting process easier. MITRE also suggested that the separation would align well with C-CDA and Continuity of Care Documents, which most EHRs already have to support. Separating Immunization from Medication will allow vendors to implement CCDs and QRDA in more similar ways.</p> <p>A representative from ONC suggested that we should talk to the FHIR team to better understand the conversation they are having around immunizations and medications.</p> <p>MITRE shared a survey of current measures and their use of immunizations with the Medication data types (mainly Medication, Administered, but also Allergy and Intolerance). MITRE then went on to suggest potential Immunization data types for Administered, Allergy, and Intolerance. MITRE also noted some inconsistencies (such as Diagnosis, Active being used to indicate allergies and Procedure, Perform used to indicate administrations).</p> <p>MITRE asked if it made sense to make these changes now, or wait and see how the conversations in other groups (i.e., FHIR) progressed. The general consensus seemed to be that we should do what’s best for Quality and not wait for external groups. That said, we <i>should</i> engage the FHIR group to better understand the issues they have discovered regarding this topic.</p> <p>From the author point of view, the proposed changes are mainly semantic. They do not add any capability that wasn’t already available in the Medication data types. From an implementer’s point of view, the proposed changes are more significant, allowing for QRDA to remove the current workaround and better align itself with C-CDA.</p>

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			<p>One of the participants asked if we should proposed Immunization, Order as a data type. MITRE stated that FHIR has ImmunizationRecommendation, which is close but not quite the same concept. Someone else suggested that whether an immunization was recommended or ordered was a nuance. Another suggested that Immunization, Order would be helpful for negation, to indicate a doctor recommended a vaccine but it was refused. MITRE asked whether Order alone was sufficient or whether recommended should be added as well, but there was no strong response.</p> <p>Another participant suggested that the proposed Immunizations are missing one important concept—it’s important to understand the <i>source</i> of the data. Did the doctor actually administer the immunization, or did the patient say they already received it somewhere else? One participant also noted that immunization records can come from a state registry. Therefore we should investigate how to indicate attribution on Immunization administrations.</p>
	3:15 PM	<p><u>QDM-37</u>: Fundamental problem with diagnosis datatypes. ...continued from last UG discussion</p>	<p>MITRE suggested that in order to progress the issue, we should divide it into sub-topics: State, DateTimes, Ordinality, Specificity, and Family.</p> <p>One of the participants suggested that Encounter Diagnosis should be considered along with ordinality. While Diagnosis tends to be patient-centric, measures often need an encounter-centric view, which Encounter Diagnosis could provide. Additionally, principal diagnosis is important, secondary diagnoses may also come into play where risk-adjustment needs to be done.</p> <p>Another participants asked how primary diagnosis works when an episode is split into multiple encounters (inpatient encounter, observation encounter, ED encounter)? The principal diagnosis may only be available for the inpatient encounter, but measures sometimes want it on the ED encounter. This seems to be a difficult problem.</p> <p>Another participant suggested that there may be another missing piece in encounters: that a problem was “present on admission.” This allows “hospital</p>

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			<p>acquired” problems to be more easily identified. In addition, there is usually an “admit condition.”</p> <p>MITRE then continued to review the individual sub-topics, going into slightly more detail on state, datetime, and ordinality. Further conversations will happen in a smaller subgroup before the next QDM UG meeting.</p>
	3:45PM	<p><u>QDM-99</u>: Intent of Diagnosis Datatypes Start Datetime ...related to QDM-37</p>	(combined with QDM-37).
	3:55PM	<p><u>QDM-101</u>: No way to indicate setting of Medication, Order or Medication, Active</p>	<i>(did not discuss due to lack of time)</i>
	4:10PM	<p><u>QDM-79</u>: Enhance Cumulative Medication Duration Representation</p>	<i>(did not discuss due to lack of time)</i>
		Conclusion	Next QDM User Group meeting will be held February 18th from 2:30-4:30PM EST.
Next steps			

Action item	Assignee
Perform a survey of products on how the principal diagnosis is captured.	MITRE
Gain a better understanding of the current immunization/medication conversation in the HL7 FHIR and Public Health groups—and bring that info back to the user group.	MITRE
Investigate options for representing attribution in immunization administrations.	MITRE

