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

Meeting date | 4/22/2015 2:30 PM *EDT* | Meeting location | Webinar video link: [*https://www4.gotomeeting.com/register/303510935*](https://www4.gotomeeting.com/register/303510935)

Attendees: Yvette Apura, Balu Balasubramanyam, Cynthia Barton, Dori Bilik, Elizabeth Bostrom, James Bourgeois, Howard Bregman, Sasha Brellenthin, Susan Campbell, Cathy Campbell, Anne Coultas, David Czulada, Michelle Dardis, Matthew Fitzgerald, Angela Flanagan, Joan Foley, Jeffrey Geppert, Ben Hamlin, Jen Harper, Yan Heras, Michelle Hinterberg, Yanyan Hu, Jamie Jouza, Joseph Kunisch, Rute Martins, Rob McClure, Chris Moesel, Lisa Nelson, Lauren Niles, LaVerne Perlie, Mike Shoemaker, Julia Skapik, Anne Smith, Kimberly Smuk, Carolin Spice, Corinne Stroum, Rebecca Swain-Eng, Dennis Tonneslan, Wallace Watson, Patrick Yamaura

| Time |  Item | Discussion/Options/Decisions |
| --- | --- | --- |
| 2:30 PM | [QDM-99](https://jira.oncprojectracking.org/browse/QDM-99): *Consider re-specifying Diagnosis Date-Time attributes* | MITRE summarized the previous month’s discussion where the user group had agreed to modify the *Encounter* datatype to add a *diagnosis* and *principal diagnosis* attributes to make that distinction. At the request of one of the participants, the topic of a *recorded datetime* was revisited, even though the group had generally agreed to dispense with it. The assertion made by one of the members was that some diagnoses may not have onset and/or abatement date times. By providing the *recorded datetime* it will allow those to anchor it to a time period. There were varying scenarios presented – one of which was a well-known EHR that has a “noted date”, a vague reference and interpreted to mean the *onset* but it defaults to current date, which is *recorded time*. That date can be changed, but seldom done; a case where the dates are fuzzy when the onset date was a few years ago; and another where an initial Encounter started with a diagnosis that changed to be something else in a month’s time. In some EHRs, a *recorded datetime* exists, but that cannot be manipulated and cannot be relied upon as the onset date for a diagnosis. The group then again discussed coded entries with SNOMED or ICD-9 and ICD-10, for which the current proposal allows two entries on *Encounter*, one of which is a coded entry that differentiates the principal diagnosis that the physician makes during the Encounter. One of the participants brought up the Ebola patient in Dallas, where it was hard to figure out when the symptoms began. When the problem started is necessary to be recorded in the case when there is a vaccine presentable disease and an infection event, and in some cases may be really important given the criticality of what occurred. There is, however, a need to balance between when it is absolutely needed and what is nice to have.One of the participants stated that the *recorded date* is all that we have in some cases. We should not assume that this is the onset date; so, this proposal makes sense. The distinction matters when these data types are used in a measure with timing relationship, so measures will need to indicate which time they are concerned with. Billing requires a minimum number of criteria, so these dates should usually be available.  Some of participants agreed that it would be better to have a *recorded date time*, and report it as such, without having to extrapolate that as *onset*. The broader concern was that we needed to make sure that it is usable and clearly defined, since temporal relationships are used in every quality measure that deals with diagnoses to define denominator populations. We specify often in EH measures that a diagnosis is *during* or shortly before an encounter, but also recognize that timing is not a good way to identify these diagnoses. When the Encounter principal diagnosis attribute is adopted, these denominator criteria can likely drop the temporal relationships, making the datetime attributes less relevant.Historically, we’ve been focused on “ongoing diagnosis” and ‘billing’ as a FFS, but never explained it well enough to physicians. As a result, physicians have not always recorded these diagnoses correctly in clinical EHR systems, which has caused unexpected results in quality measurement. It is important that physicians record the diagnoses they are managing in every relevant encounter.This topic should be run past a larger vendor/stakeholder group before finalizing. |
| 3:00 PM | [QDM-41](https://jira.oncprojectracking.org/browse/QDM-41): *Diagnosis attribute of laterality should be retired* | One of the participants stated that in general, the newer models are moving to a post-coordinated approach and was concerned whether removing the *laterality* attribute will force it to be re-entered later. MITRE informed the group that in FHIR, the *condition* can be represented using a since pre-coordinated code or a body site resource, which has a modifier code as well. Most participants agreed that retaining the *laterality* attribute is not necessary, since it is not used in quality measures. The use of post-coordinated laterality in the quality of care will be rare. It was also confirmed that in SNOMED, for general pain, there are appropriate codes for laterality (e.g. abdominal and chest), and not needed in the model.The participants also confirmed that dental measures might need “laterality” to describe sealant on each tooth, but that attribute was being used on the *procedure* data type and not *diagnosis*. |
| 3:30 PM | [QDM-115](https://jira.oncprojectracking.org/browse/QDM-115): *Consider re-specifying Symptom datatype* | MITRE presented the problem and stated that the FHIR specification says that symptoms may be recorded as conditions or observations. There is nothing that shows an *assessed* modifier that would indicate otherwise.One of the participants stated that in terms of terminology modeling this was confusing. If the physician has done something to address the symptom, it is an assessment that is based on an observation, but not necessarily a diagnosis – which will have a confirmation through tests. These are meta data of complexities that align with care, and argued that assessment is superfluous. Multiple participants agreed that assessments are observations in the HL7 – FHIR, RIM models. This led to a short discussion about the importance of attribution (who or what is the source of data) – a topic that is still difficult in many clinical models.Many participants agreed with removing *Symptom, Assessed* and consolidating the other Symptom datatypes to a single *Symptom* datatype. One of the participants also added that there was a resource called Health Concern Entry that wraps multiple problem observations. The “Problem type” value set captures, problem, observation, symptom, etc, and maybe that is a good place to begin to harmonize QDM, QRDA and CDA. Maybe that is where the categorization could help.The participants were in agreement that we should remove *Symptom, Assessed* and consolidate the remaining Symptom datatypes into a single *Symptom* datatype (similar to the Diagnosis resolution). Consensus was achieved and this proposal will be brought forward.  |
| 4:00 PM | [QDM-107](https://jira.oncprojectracking.org/browse/QDM-107): *Consider re-specifying family history* | MITRE stated that in specifying family history, there was no mechanism to indicate the relationship of the person. FHIR and CCDA have more robust models for family history. For example, CCDA has a family history organizer that indicates the relationship to the person, whether or not they are deceased, what health problems they had (with their effective times), etc. A participant stated that SNOMED uses “context” to represent family history, and it is unburdened from what currently happens, while another stated that clinically, it would be valuable to care about the onset age of the relative, in cases where, say, the father died when he was less than 50 years (as opposed to if he died when he was more than 90 years old). The family member’s closeness to you in the family hierarchy was also seen as relevant. There was a suggestion to talk to people who do genetics work in the EHR community to see how they model family history.Another participant provided information that a lot of work had been done in the CDA model in the concept of family history organizer. It has a person, a deceased indicator, etc. There is a new template in CDA – Care plan => functional assessment / and the modeling has not been thought out yet.Regarding how to capture outcomes, the participants stated that outcome as they relate to death or permanent disability may be important, but it is not currently recorded in EHRs. Another participant noted that in HL7 outcomes are typically related with interventions, not observations or problems themselves. Another participant asked if the outcome of a family member’s problem would really be used for a quality measures? The participant suggested it would not. There were no further responses from anyone else in the group. This topic will be continue to be discussed in subsequent meetings. |

|  |  |
| --- | --- |
| **Action item** | **Assignee** |
| Further refine the proposal for QDM-107 | MITRE |