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

Meeting date | *5/20/2015 2:30 PM EDT* | Meeting location | Webinar video link: *https://www4.gotomeeting.com/register/303510935*

Attendees: Lisa Anderson, Balu Balasubramanyam, Cynthia Barton, Kimberly Bodine, Zoe Bolton, Dharaneesh Bommireddypalli, Howard Bregman, Sasha Brellenthin, Zahid Butt, Cathy Campbell, John Carroll, Jeffrey Clyman, Nicole Cormier, Anne Coultas, Dave Czulada, Michelle Dardis, Karen Dorsey, Jay Frails, Jeffrey Geppert, Jyothi Golkonda, Ben Hamlin, Sharon Hibay, Michelle Hinterberg, Yanyan Hu, Megan Keenan, Joseph Kunisch, Rute Martins, Susan Mateja, Christopher Moesel, David Nilasena, Lauren Niles, Mallory Perez, Kala Ramesh, Stan Rankins, Juliet Rubini, Jessica Smail, Anne Smith, Carolin Spice, Corinne Stroum, Naresh Sundar Rajan, Wallace Watson, Suzanne Webster, Sherry Wiedow, Jenna Williams-Bader, Patrick Yamaura

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2:30 PM	QDM-114: *Need the ability to support reference ranges for laboratory tests in eCQMs*	Karen Dorsey began the discussion by providing an overview of the Core Clinical Data Elements (CCDE). In short, the CCDE are "a set of data elements feasibly extracted from hospital electronic medical records that can be used to risk-adjust hospital outcome measures in the HIQR program." The CCDE are specified using the same standards as eCQM (QDM, HQMF, QRDA, etc.). Karen then provided the specific use case regarding the measurement of troponin. Troponin T or I proteins are released in the blood when the heart muscle is damaged. "Normal" levels of troponin are *low*. The upper limit of what is considered "normal", however, differs depending on the laboratory and/or type of test used to measure the troponin. The CCDE use a ratio of *actual test result value / reference range high value* to determine the severity of the heart damage. This requires the *reference range* to be reported in QRDA, which in turn, requires a way to request the *reference range* using QDM and HQMF. MITRE then presented a proposal for new *reference range low* and *reference range high* attributes on the *Laboratory Test, Performed* data type, and opened up the topic for conversation. One participant noted that laboratories send back a flag indicating if a result is *abnormal*. Could that flag be used instead? Karen indicated that the flag would not be sufficient, as they need to understand the severity as as a scalar, in order to fairly compare hospitals. The value will be used as a continuous variable (CV). Another participant asked if the LOINC codes could be used to determine the upper limit of the "normal" reference range. One participant familiar with the CCDE indicated that *some* LOINC codes encode the range, but not *all* LOINC codes. If a hospital reported using one of

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		the more general LOINC codes, the reference range would not be able to be extracted. In addition, not all possible troponin test methods (and reference ranges) have distinct LOINC codes. Another participant then indicated that new LOINC codes could be created if necessary. Another participant cautioned that while the data for reference range is available in lab test results, it might not be available discreetly. That said, the concept of using reference ranges in eCQMs seems fair and should be supported. The main concern, voiced by a few participants, was that adding a discrete reference range, separate from the LOINC code, introduces an opportunity for errors. An incorrectly reported reference range could have unfortunate consequences in risk modeling. Depending only on the LOINC code would be more accurate. Another participant suggested that we couldn't expect an ideal world where this can all be solved by LOINC. We may need to normalize to a local reference range, as proposed here. Someone else also reminded the group that QDM does not prescribe where the data is stored, so it is possible that the reported reference range can still be extracted from the LOINC code when the report is created. Several other participants also came out in support of adding the reference range attributes to *Laboratory Test, Performed*. The data is available, it makes sense for it to be queryable, it's not hard to imagine other use cases, and other standards (e.g., C-CDA, FHIR) already support it. MITRE indicated that it heard more supporters of the proposal than otherwise, so it would move this proposal on to the next step and bring it to the MCCB. MITRE also indicated that the MCCB would be made aware of the concerns raised in this discussion so that they can make an informed decision.
3:00 PM	QDM-107: *Consider re-specifying family history*	MITRE proposed a solution that renames *Diagnosis, Family History* to *Family History*, and supports the following attributes: *relationship*, *onset age*, *recorded datetime*. The value set applied to *Family History* indicates the diagnosis the family member had (e.g., Diabetes). One participant asked if the *relationship* indicated gender. MITRE answered that most relationship codes do indicate the gender (e.g., father, mother, grandfather, grandmother, etc.).

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		MITRE asked if the *onset age* could be defined as age in *years*, or if it needed to be more precise. After a small amount of discussion, the user group concluded that *year* granularity would be sufficient. MITRE also asked if it was necessary to represent the notion that a family member *did not* have a certain diagnosis (*evidence of absence*, as opposed to *absence of evidence*). The user group determined that this was not needed now, but could be added in the future if sufficient use cases arose. The UG agreed to the proposed change, and MITRE indicated it would move it to the next step in the process (bringing it to MCCB).
3:30 PM	QDM-108: *Patient provider preference*	MITRE introduced the topic by indicating the difficulty in mapping QDM's *patient preference* and *provider preference* attributes to FHIR and other data models. In practice, the meaning of these attributes is often ambiguous, or might not even make sense in the context of certain data types (e.g., *Medication, Intolerance*). In addition, use cases for quality measurement have been difficult to find. The most promising use cases are when a patient preference is used as a reason for *not* doing something, but these are better represented using *negation rationale*. Despite *patient preference* and *provider preference* being available for many years, they have never been used in any MU measure. After brief discussion, the user group unanimously concluded that these attributes should be entirely *removed* from the QDM. MITRE indicated that this proposal would be brought to the MCCB.
4:00 PM	QDM-109: *Negation rationale cleanup*	MITRE introduced the topic by indicating the difficulty of mapping certain data types' *negation rationale* to FHIR and other data models. For some data types, the meaning and mapping are quite clear, but for others it is much more ambiguous. MITRE proposed that *negation rationale* be removed from *some* data types, including all *Adverse Event* data types, *Family History*, *Patient Care Experience*, *Provider Care Experience*, and *Provider Characteristic*. MITRE then shared a slide indicating which data types have instances of *negation rationale* that are currently in use in MU-2 measures. MITRE then opened the topic for conversation. One UG participant suggested that *negation rationale* should also be removed from *Care Goal* and *Diagnosis*. Another participant suggested it be removed from all *Allergy* and *Intolerance* data types as well. MITRE asked if *negation rationale* was ever used to indicate the *non-*

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		occurrence of a *Diagnosis*, *Allergy*, or *Intolerance*, but the UG confirmed that this was not a proper use of *negation rationale*. A UG participant then suggested that this could be simplified by indicating that *negation rationale* is only valid on those data types that represent an *action*. Since *negation rationale* represents "the reason that something did not occur or was not done", it only makes sense in the context of *actions*. Therefore, *negation rationale* should be removed from all data types that do not represent actions, unless it is already in use in MU-2 measures. The UG agreed to this suggestion. MITRE indicated it would review the data types and apply the suggestion regarding how *negation rationale* should be applied. MITRE will then bring this proposal to the MCCB.

Action item	**Assignee**
Present QDM-114, QDM-107, QDM-108, and QDM-109 to the MCCB for consideration.	MITRE