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Lantana Comments on NQF QDM Update June 2012

Lantana Consulting Group (Lantana) welcomes the opportunity to comment on the National Quality Forum's (NQF) Quality Data Model (QDM) update, released June 2012. Our comments focus on those areas of particular relevance to our quality measure retooling expertise.

Lantana's work focuses largely on interoperability specifications, which we see as more of a means to an end, that end being a more data-driven healthcare system. Our mission is to transform healthcare through health information. Lantana's principals, analysts, and developers have served as primary authors for CDA, CCD, Consolidation, QRDA, and eMeasure. Bob Dolin, President and Chief Medical Officer at Lantana, is past Chair of HL7 and prior Co-chair of HITSP's Foundations Committee.

Please contact us if Lantana can provide further information or if you have any questions regarding our comments.

Sincerely,

Liora Alschuler — Chief Executive Officer
Bob Dolin, MD — President and Chief Medical Officer

Lantana Consulting Group

NQF QDM Update June 2012

Table 1: QDM Category Definitions

Adverse effect: non-allergy (p. 17)
It is unclear whether a *drug-drug interaction* belongs under *Adverse effect: non-allergy*. If so, does the attribute of *causative agent* allow more than one value? For example, if a patient is administered warfarin and amiodarone concurrently, the patient risks increased warfarin concentrations and bleeding. To capture this example criterion, we would use the *Adverse effect: non-allergy* category, bound to a SNOMED code, such as "404204005 drug interaction with drug (finding)." The two drugs would be captured as *causative agents* with cardinality of one to many. However, *causative agents* with cardinality of more than one are unclear.

Care goal: (p. 18)
The term *Care goal* is misleading because it is not possible to represent a clear care goal under a single category. Care goals are often represented as a full sentence with multiple components, e.g., "Reduce the systolic blood pressure from 250 to 160 in six weeks." This goal cannot be represented by a single concept with a value set.

Functional status (p. 21)
Lantana disagrees with the proposal to divide *Functional status* into general and disease-specific sections. This level of detail is appropriately accommodated by the value set.

Risk evaluation (p. 23)
It is very difficult to distinguish between the *Functional status* and *Risk evaluation* categories. Lantana recommends removing *Risk evaluation* because it is only a subjective assessment of raw data.

Symptoms (p. 24)
Lantana questions the value of *Symptoms* being a separate category. Symptoms are most likely to be captured under the *Conditions/diagnosis/problem* category as entries in the problem list.

Health record component (p. 22)

NQF should provide clear guidance and corresponding examples on when and how to use the *Health record component* category versus the *health record artifact* attribute, especially when the same criterion can be represented using each. For example, "Statin prescribed at discharge" could be represented one of two ways:

1. Health Record Component: Discharge Medications (medication list containing statin); OR
2. Medication Order: Statins (*health record artifact* "Discharge medication list")

Table 4: Category–specific Attributes

Method attribute (pp. 35 and 40)

The *Medication* category needs an *administration method* attribute. It is unclear if the *method* attribute can support this need.

Other category-specific attributes (pp. 34-36)

Patient and *provider* should be subject attributes to the *Characteristics* category. This would also apply to other QDM categories (e.g., *Medications*, *Procedures*); however, the attribute would change depending on the subject being addressed (e.g., mother, baby, grandparent). This design will allow greater extensibility for quality measures that need to distinguish separate subjects and associate measure phrases with the corresponding subject.

Table 6: Relative Timings

Associated with (p. 44)

Consider adding a relative timing for *associated with* to allow linkage of QDM categories. For example, medication A is *associated with* encounter A; medication B is *associated with* encounter B. Currently, measure developers have to define the phrase as a "medication *during* encounter," requiring EHRs to translate the phrase into associations since medications are typically associated with an encounter ID in a database.

Changes to States

Declined state (p. 51)

The description of the *declined* state has a lot of similarities to *negation rationale*. Lantana recommends that these states be consolidated.