NATIONAL QUALITY FORUM

Quality Data Model, Version 2.1 Member and Public Comments

	Comment Submitter Name	Comment Submitter Organization	Question	Comment	NQF Response
1	Ardis D. Hoven, MD/ Bernard M. Rosof, MD, MACP* * AMA/ PCPI comments combined for comment period response draft	American Medical Association/ Physician Consortium for Performance Improvement	General	The American Medical Association (AMA)/ Physician Consortium for Performance Improvement is pleased to have the opportunity to comment on the National Quality Forum's (NQF) Quality Data Set (QDS) Model, Version 2.1. We applaud the NQF for its continued efforts in developing this important tool. By clearly defining the elements that are a part of clinical performance measures, the QDS provides a common language for measure developers and those who wish to integrate clinical performance measures into electronic health record systems. Our comments are outlined below.'	Thank you for your comment.
2	Ardis D. Hoven, MD	American Medical Association	General	'The QDS Conceptual Model In our previous comments to version 2.0 we inquired about the overarching conceptual model that defines the scope of the QDS model. Though we recognize that the QDS model as it stands is currently included in the CMS EHR Incentive Program, we believe certain changes would be helpful to make it more robust. In order to effectively comment on the structure and content of the QDS, we see a need for greater specification with regards to the QDS model. In particular, how are patterns (class, attribute, category, data type or otherwise) constructed? We note that there are several structural inconsistencies in the current version of the QDS that could be corrected by having a more complete model with which to perform cross checks. For example, there needs to be a greater	Thank you for your comment. The recently released version of the Quality Data Model (QDM), Version 3.0 contains greater specification that includes attributes. Attributes were added to this version following NQF's completion of converting 113 NQF-endorsed quality measures into an electronic format, the eMeasure. In this process, attributes were used to provide precise information about how QDM elements are used in an eMeasure. Attributes were classified into four types: Timing, Data flow, Actors, and Concept-specific attributes. For more information about attributes, an Implementation Guide is forthcoming. The QDM's expansion to accommodate attributes makes the QDM more robust. Specifically, attributes allow clinical concepts to be more precisely specified in an eMeasure, programmed in EHRs, and reported in a more consistent manner.

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				distinction between all Standard Categories and Quality Data Types. [continued in next comment]'	The QDM was used in 44 measures that were published in PDF format in the Centers for Medicare and Medicaid Services' Electronic Health Record Incentive Program Final Rule, released in July 2010. Further use of the QDM will be determined by HHS.
3	Ardis D. Hoven, MD	American Medical Association	General	'[continued from previous comment] As it stands now, 2 categories and their corresponding data types are identical (Risk Category Assessment and System Characteristic). We see this as similar to defining a particular word with the word itself. With regards to these two categories, we suggest the following: for Risk Category Assessment, we recommend changing the Standard Category to 'Risk Evaluation' so as to identify the object of Risk Evaluation/Assessment. For System Characteristic we recommend changing the Standard Category to 'Organizational Feature' or 'System Feature' so as to identify a specific feature about the system, which would be the 'characteristic." Moreover, we believe that without greater model specificity, it is impossible to understand, evaluate and apply the American Medical Association between different Standard Categories and Quality Data Types. As one example, how do "individual patient characteristics" relate to "intervention intolerance?"	Thank you for your comment. Based on this input, the NQF modified both clinical concepts in the newly released version of the QDM. "Risk category assessment" is intended to capture the completion and documentation of surveys or assessments that evaluate a patient's risk. The term has been modified to "Risk evaluation." As the commenter notes, "System characteristic" captures features of settings where health services are delivered or organized. The term has been modified to "System resources."

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4	Ardis D. Hoven, MD	American Medical Association	General	'Legal Documentation Category We would like to resubmit our comment that there should be a standard category for "Legal Documents Related to the Delivery of Health Care," for example, a durable power of attorney for health care and advanced directives. We do not agree with the response provided to this comment that these types of legal documents can be managed with standard category "individual characteristic" and data type "patient characteristic." In our reading of the definition of "patient characteristic", legal documents would not fit in this data type. We again recommend that the QDS model be modified to include this category, with data types for the different types of Legal Documents Related to the Delivery of Health Care.'	Based on your comments, we examined this issue further. We agree that legal documents as a concept that requires versatility in its application in the QDM. For example, the terms of advance directives or durable power of attorney could be applied in a quality measure to reflect an individual's characteristic or preference. These terms are appropriately reflected in a measure's code list that could be applied to a variety of different clinical concepts, such as preference and characteristics.
5	Ardis D. Hoven, MD	American Medical Association	Condition/ Diagnosis/ Problem	'Aligning with CMS Guidelines for Reimbursement In order to align with CMS' Guidelines for Reimbursement: Definition of Condition/ Diagnosis/Problem we suggest that the word 'following' and the phrase 'to include, but not limited to' be included within the statement we previously suggested below: • Category: Condition/diagnosis/problem • Condition/diagnosis/problem ADD: "or a clinical feature which includes but is not limited to those treated, monitored, evaluated,	Based on your comment, the definition has been modified.

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				followed, or impacts the encounter or length of stay”'	
6	Ardis D. Hoven, MD	American Medical Association	Encounter	'We believe that it would be helpful to include a “venue of care” (e.g., ICU) data type as a part of the “encounter” standard category.'	The newly released version of the QDM handles “venue of care” as an attribute of the standard category, “encounter.” By specifying this information at the attribute level, the Model remains versatile and adaptable to coding variation in local care practices.
7	Ardis D. Hoven, MD	American Medical Association	Patient characteristic	'The AMA believes it would be helpful to include some additional individual “patient characteristics” that will come up often in the coding of measures, for example, age and gender.'	Thank you for your comment. The concepts of age and gender are captured as attributes, for which, there is standard electronic representation.
8	Ardis D. Hoven, MD	American Medical Association	General	We note that the taking of vital signs is difficult to fit into an existing category. We recommend that guidance be provided regarding how to classify the taking of vital signs in the QDS.	The documentation of vital signs is handled through the “physical examination” standard category.” If a given measure called for specific methods of taking vital signs, the eMeasure would contain the appropriate guidance.
9	Ardis D. Hoven, MD	American Medical Association	Communication	We note that two types of provider to patient communications are difficult to capture with specificity within the existing categories: the act of providing a referral to a patient and the act of counseling a patient. We recommend that guidance be provided regarding how to classify these in the QDS.	Based on your comments, we examined this issue further. Different types of communication, specifically, referrals and counseling are forms of interventions and would be handled as an attribute of the concept, “communication.” To accommodate the concepts of referrals and counseling, the state “recommend” has been added to the concept, “intervention.”
10	Ardis D. Hoven, MD	American Medical	General	We request that patient and systems reasons for exceptions be more adequately delineated.	System reasons for exclusion in a quality measure may be drawn from structural characteristics or

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		Association			features of a care delivery or organization setting; patient reasons for exclusion reflect individual preferences, such as a religious reason to decline a service.
11	Joseph Drozda	American College of Cardiology	General	'Many of the categories that include an "order" quality data type are nonsensical from a clinical and practice viewpoint. In other words, it is not the practice among clinicians to enter orders for these items and, therefore, no accommodation has been made for such in CPOE systems. Specifically: Device - While the parent procedure is often times scheduled (=ordered), the "order" for the device is implicit, not explicit - making this data type impossible to capture. For example, one could place an "order" to schedule a pacemaker implant, but there is no explicit order for the pacemaker as a device. Functional status assessment - This is not routinely "ordered" but instead is something that is done as part of routine clinical assessment. Physical exam - A physical exams is not "ordered; it is a standard component of the H&P. The proposal to use this terminology for a clinician order for vital signs will lead to confusion among users since this terminology is not a part of the normal clinical lexicon.'	Based on your comment, we examined the term "device," for which the implantation of a device is recommended and planned. The state "plan" has been added to accommodate this context of use. The state "order" in the current model will be retained to accommodate non-physician orders.
12	Joseph Drozda	American College of	General	The American College of Cardiology had previously expressed concerns about including	Based on your comment, Family History has been added as a Concept and is no longer a state that is

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		Cardiology		"family history" in the same category with diagnosis since the 2 concepts do not reside in the same clinical context. No changes were made to this construct in v.2.1. We continue to advise that listing family history as a "condition" or "diagnosis" does not make sense. The ontological relationship is not the same as the other measures of this category.	applied to Condition/Diagnosis/Problem.
13	Joseph Drozda	American College of Cardiology	General	The American College of Cardiology is pleased to be able to comment on NQF's Quality Data Set Model v.2.1. There have been significant improvements made to the document since the earlier version but we still have concerns.	Thank you for your comment.
14	Rebecca Zimmermann	America's Health Insurance Plans	General	AHIP appreciates the opportunity to review the revisions to the QDS. We support all proposed revisions as they appear to be minor refinements to the model and do not change the content of the data set.	Thank you for your comment.
15	Diana Jolles	American College of Nurse-Midwives	General	'We noted the change from consumer to patient, but would encourage you to consider reversing the change. In effort to demonstrate the goal of wellness, HIT throughout the lifespan, AND the ideal system where 'patients' have choices regarding the location, type of care provider, and components of care consumption- consumer seems more appropriate.'	Based on your comment, we reevaluated the decision to modify the term "consumer" to "patient". We are retaining the term "patient" as the term "consumer" is inclusive of patients," but "patient" may not be inclusive of consumers in all applications. The attributes in the newly released version of the model allow for specific description of the individuals to whom a quality measure is directed. For example, with the requisite standard terminology in place, a quality measure can consider patients, care givers, clinical providers, social

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					workers, etc.
16	Diana Jolles	American College of Nurse-Midwives	General	'Where are overuse, appropriate use, optimality and meaningful use grounded within this conceptual framework?'	Thank you for your comment. These are critical concepts that will be present in future measures. The QDM will continue to evolve in to support these concepts as data are available.