No.	Org. Contact	Type of Comment	Comment	NQF Response
219	John Shaw, Next Wave	general	The added category definitions DO improve clarity - good idea.	Thank you for your comment.
220	John Shaw, Next Wave	general	The Model divides concepts into broad categories that can be different than those familiar to each user. Beginning with a list of each of the broad categories with hyperlinks to the data types and definitions would be useful to those new to the QDS model structure. Capitalizing the Categories and leaving data types in small letters can also help visually distinguish them. Some examples: 1. Diagnostic Study and Laboratory Test are individual categories in QDS, but frequently associated with each other by many users. In descriptions, where one is excluded from the other, we suggest putting in reference to the other and <hyperlinks> to clarify e.g. under Diagnostic Study "...those not performed in the clinical lab" (see <Laboratory Test>). This would provide an immediate answer to "If not here, where?" and a quick means of navigating there. 2. This applies to all the categories where exclusions are used (e.g. Negation Rationale, substance, not done "...cannot otherwise be specified (e.g., such as by using <Diagnosis>, <Device>,..."	Thank you for your comment. NQF added a list of all QDS standard categories and data types to the end of the QDS Model Version 2.1. Interrelated categories will include cross-references to each other.
221	Phil Renner, NCQA	general	Overall, the QDS represents a significant contribution to the field, and NQF is to be commended for incorporating lessons learned from retooling in this version of the QDS. We would recommend that NQF pair the QDS Model with an explanatory document or user's guide. It is difficult to put the QDS grid into context without a user's guide.	NQF plans to create a basic users guide to help explain the purpose of QDS, how to use it, and where/when the QDS can be applied. Over time, NQF will also develop use case examples (e.g., QDS in quality measurement, clinical decision support, research, etc.) to provide more detail and context for how and where QDS can be used, particularly beyond quality measurement.

No.	Org. Contact	Type of Comment	Comment	NQF Response
222	Phil Renner, NCQA	general	The term "QDS" seems to be used for both the information model and the database tool that is being used to support retooling. Since the information model and the database tool will be used differently by different stakeholders, we recommend names that distinguish the two.	NQF will clarify the terminology. The model will be referred to as the QDS and the interim tool or database will be referred to as the Interim Measure Authoring Environment.
223	Phil Renner, NCQA	Other	In the document "QDS: Technical Questions and Answers", answer #6 states that the "QDS translates…". We would suggest a different wording, in that the QDS does not perform a translation. Alternative wording could include: "The QDS provides a map, enabling measure developers to translate…"	NQF accepts the proposed wording changes and modified the language.
224	Phil Renner, NCQA	general	In future versions, it may be helpful to specify whether data types are expected to be represented by structured and coded data. If so, please also specify NQF expectations for specific code sets or terminologies. We realize that this question is being actively addressed through retooling, but it would be very helpful to have these expectations clearly documented.	Data types are expected to represent structured and coded data. NQF does not specify terminologies but rather works to aligns with national harmonization efforts. Specific terminologies are defined by prior US national standards harmonization work efforts (for example, the Health Information Technology Standards Panel), the Office of the National Coordinator for HIT's Standards Committee Operations Workgroup recommendations, or certification rules, whichever is most recent. Where gaps exist, NQF refers the requirement to the HIT Standards Committee.

No.	Org. Contact	Type of Comment	Comment	NQF Response
225	Phil Renner, NCQA	general	Many data types are labeled with “time/date stamp is required”. While time stamps are desirable for many data elements, and should be a part of the EHR workflow, we see three issues. First, time/date should be thought of as an attribute or additional data element attached to something like a procedure or order, rather than a part of the data type itself. Second, a measure may not require a specific time/date, and so requiring a timestamp may unnecessarily constrain the data element. Third, if the data element is not available in the source system, it is not clear how to handle the missing value. We would recommend either making the timestamp optional, or treating timestamp as an attribute of the data element.	NQF has modified QDS Model Version 2.1 to indicate date/time as an attribute of any data type. In EHRs, each element has a time it occurs or is stored in a database; therefore, there should be a date/time for everything. A measure indicates the necessity of date, time, or other attributes. Each measure indicates criteria required for calculation. Presence of each element in an individual patient record is a concern for reporting, not for setting the measure criteria and indications.
226	Phil Renner, NCQA	general	Many data types are labeled with “time/date stamp is required”. However, many measures only require the date of a service. Please clarify whether date can be substituted for time/date, or if there is a minimum degree of specificity permitted for timestamps.	NQF added this clarifying statement in the QDS Model Version 2.1: 'based on measure requirements' for time/date stamp.'
227	Phil Renner, NCQA	diagnosis	We agree that the data type “Diagnosis, past history” be deleted and replaced with the “inactive” and “resolved” data types for clarity.	Thank you for your comment. 'Diagnosis, past history' was previously removed as a data type in QDS Version 2, as 'Diagnosis, inactive,' 'Diagnosis, resolved,' or 'Diagnosis, active' provide the ability to define past history.
228	Phil Renner, NCQA	functional status	It is not clear what the data type represents. It may be helpful to break into “functional status, administered” and “functional status, result”, similar to the schema for laboratory tests. This will allow measure developers to specify the use of the results of a functional status test in a measure.	For the standard category 'Functional status,' NQF added the following data types in the QDS Model Version 2.1: 'Functional status, ordered,' 'Functional status, performed,' 'Functional status, result' and 'Negation rationale, functional status not done.' For the purpose of clinical decision support and care plans, more process oriented steps are required.

No.	Org. Contact	Type of Comment	Comment	NQF Response
229	Phil Renner, NCQA	functional status	As in other areas it would be helpful to have examples of what is (mental status exam or ADL, IADL) and isn't a functional status indicator. For example is Please specify whether administering a PHQ9 as a depression screening tool is a risk assessment or a functional status test. What about repeat PHQ9 to monitor effectiveness of depression treatment? What code set will count towards functional status (ICD 9, SNOMED, CPT, etc)?	In the QDS Model Version 2.1, NQF provided specific examples and enhanced the definition of functional status as follows: "Functional status assessment is specific to tools that evaluate an individual patient's actual physical or behavioral performance as an indicator of capabilities at a point in time. The functional status assessment can be used in measurement to determine change in physical or behavioral performance over time, or specific capabilities that cause a patient to be included or excluded from a measurement population." Examples include (but are not limited to): Eastern Cooperative Oncology Group (ECOG) Performance Status, Edmonton Functional Assessment Tool (EFAT), Karnofsky Performance Scale, Katz Index of Independence in Activities of Daily Living, Palliative Performance Scale version 2, the Medical Outcomes Study (MOS) Short Form Survey Instrument (SF-12), Asthma Quality of Life Questionnaire. Alternately, 'risk assessment' refers to appraisals of health and well-being, providing information as to the risk for conditions or increased severity of illness (e.g., Braden Skin Scale, Morse Fall Risk Scale, etc.), whereas 'physical exam' includes psychiatric examinations.

No.	Org. Contact	Type of Comment	Comment	NQF Response
230	Phil Renner, NCQA	intervention vs. procedure	It is not clear what an intervention is, ? recommending or prescribing a treatment or doing counseling? compared to a procedure or encounter, especially in the context of behavioral health. Many behavioral health interventions might be considered as procedures or encounters.	In the QDS Model Version 2.1, NQF enhanced the definition of intervention as follows: "An intervention is an action - treatment, procedure or activity - designed to achieve an outcome. Interventions are distinct from encounters, diagnostic tests, laboratory tests or procedures, each of which is a step in any individual patient's care process. Interventions represent those care activities that can be performed by a clinician, a patient or a caregiver and require supervision, monitoring or communication. Interventions represent a broad category of activities that are distinct from diagnostic tests, procedures, laboratory tests or encounters. Included are education, communication, physical actions (dressing change, ambulation with or without assistance), use of inhalation devices, provision of nutrition, exercise, use of psychosocial interaction or relaxation techniques, to name a few. To distinguish interventions from the category 'procedures', procedures can be specifically identified and used in reimbursement schema (e.g., surgical operations, chiropractic manipulation, setting of bone fractures and placement of a cast. Both procedures and interventions can generate a claim for payment but a claim is not necessarily created. Examples: (1) instruction in walking with crutches is an intervention yet there is a billing process for reimbursement, (2) periodic oral evaluation and cleaning are procedures (generally performed by a dentist and oral hygienist), yet mouth care is an intervention as it is a routine process performed by a patient, caregiver or clinician." It is understood that the industry is currently discussing how to best handle the concept of 'intervention' and it is expected to evolve.

No.	Org. Contact	Type of Comment	Comment	NQF Response
231	Phil Renner, NCQA	functional status	An example code set example, specifying RxNorm, is given. Given our prior comment about code systems, this may be a good way to list suggested or required code systems for each data type.	NQF does not specify the terminologies, but rather works to align with national harmonization efforts. Specific terminologies are defined by prior US national standards harmonization work efforts (HITSP), the HIT Standards Committee Operations Workgroup recommendations, or certification rules, whichever is most recent. No specific terminology has been identified for Functional Status Assessment or Interventions, for each LOINC, SNOMED; International Classification of Functionality (ICF) may have a value. Where gaps exist, as is the case here, NQF refers the requirement to the HIT Standards Committee.
232	Phil Renner, NCQA	general	This comment is addressed to the phrasing in several data types that states "patient reported/provider verified". It isn't clear exactly what this means (if the provider writes the information in the chart-is that verification?), or why this is required for many data types. If the measure developer does not specify whether an item is patient reported or provider verified then this requirement adds a constraint not specified by the developer. This can be optional, or can be a separate attribute of the data element like the timestamp.	NQF will modify the relevant data type definitions to indicate that patient report or provider verification specificity is not required.

No.	Org. Contact	Type of Comment	Comment	NQF Response
233	Rita Munley Gallagher, American Nurses Association	general	The American Nurses Association concurs that the lack of a set of precisely defined, universally adopted electronic quality measures is an obstacle to automating measurement, and comparing and improving quality using electronic health information. ANA applauds NQF's efforts to describe information so that electronic health record (EHR) and other clinical electronic system vendors can consistently interpret and easily locate the data required. NQF's efforts in that regard are laudable. Furthermore, ANA appreciates the clarity of the tabular presentation format. The document is clear and translucent and will assist in the specification of clinical elements to facilitate data capture and retrieval. However, the American Nurses Association respectfully requests that this (and any other) NQF document use more inclusive language when describing the universe of clinicians engaged in the delivery of health care.	Thank you for your comment. In the QDS Model Version 2.1, NQF replaced the terms 'physician' with 'clinician' unless 'physician' was absolutely required.
234	Rita Munley Gallagher, American Nurses Association	general	The American Nurses Association finds the definitions added to the document to be assistive in adding clarity. They emphasize the importance and expectation of holistic care and include: patient/family centered care, interprofessional collaboration, and effective communication. ANA appreciates the interprofessional nature of the care plan which incorporates the perspective of all stakeholders, including the patient.	Thank you for your comment.

No.	Org. Contact	Type of Comment	Comment	NQF Response
234.1	Rita Munley Gallagher, American Nurses Association	laboratory test	However, the American Nurses Association has concerns with the definition of "laboratory test." ANA finds the definition as presented as being too restrictive. Laboratory tests can/should also be conducted on non-body substances, e.g., cultures of walls, medical equipment, and other fomites. Laboratory tests on non-body substances may be necessary for the purposes of quality measurement. For example the Australian Council on Healthcare Standards measure: Occupational Exposure: percentage of reported non-parenteral exposures sustained by staff, during the 6 month time period suggests collecting "additional data relating to injury such as the type of injury, the activity surrounding the injury and any factors relating to devices, equipment or human behaviour which may have contributed to the exposure." ANA recommends revising the definition to read: A medical procedure that involves testing a sample of blood, urine, or other substance from the body, or non-body substance such as medical equipment. Tests can help determine a diagnosis, plan treatment, check to see if treatment is working, monitor the disease over time, or determine the source of an infection.	In the QDS Model Version 2.1, NQF expanded the definition of laboratory test as follows: "Laboratory tests may be performed on specimens not derived from patients (electrolytes or contents of water or consumed fluids, cultures of environment, pets, other animals). The data types will remain the same."
235	Jodi Mitchell, American Optometric Association	general	The American Optometric Association has reviewed the most recent Quality Data Set (QDS) Model and commends the National Quality Forum and the Health Information Technology Expert Panel (HITEP) for the efforts to define QDS standard categories, data types, previous definitions and current definitions. We are pleased that there is acknowledgment that updates will be necessary as quality measurement is further enhanced and as data collection efforts are expanded.	Thank you for your comment.

No.	Org. Contact	Type of Comment	Comment	NQF Response
236	Mark Antman, American Medical Association	general	The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) Quality Data Set (QDS) Model – Version 2. We applaud the NQF for the continued attention it has given to this topic and agree that it is imperative to maximize the benefits of electronic health record systems (EHRS) technology and leverage their use for deriving performance measures and ultimately improve the quality of care delivered.	Thank you for your comment.
236.1	Mark Antman, American Medical Association	general	*Overarching Comments* The AMA/PCPI recommends that the final publication of the QDS include more robust documentation about the QDS, including its intentions, why it is needed, and who its users will be. While the AMA is familiar with the QDS, our sense is that there continues to be confusion regarding these questions. We believe this project is worthwhile and we hope that buy-in from potential users and its ultimate adoption occur as smoothly as possible.	NQF plans to create a basic users guide to help explain the purpose of the QDS, how to use it, and where/when the QDS can be applied. Over time, NQF will also develop use case examples (e.g., QDS in quality measurement, clinical decision support, research, etc.) to provide more detail and context for how and where QDS can be used, particularly beyond quality measurement.

No.	Org. Contact	Type of Comment	Comment	NQF Response
236.2	Mark Antman, American Medical Association	general	The AMA/PCPI recommends that NQF establish a maintenance process for the Quality Data Set to allow for additional categories and data types to be added to the QDS model. As the use of quality measures increases and quality measures evolve, additional categories and data types will be needed. A regular QDS model update schedule will establish the QDS as a sustainable, flexible model that can incorporate new categories required for quality measures in future years.	NQF recognizes the need for QDS to evolve as quality measures change and new data types and categories are needed. As such, NQF has established a QDS maintenance process. Specifically, the current model will be posted and public comment will be solicited. As comments are reviewed and resolved, a new version of the QDS will be posted, at least semi-annually. For example, comments received on the QDS Model Version 2 in July 2010 were reviewed and incorporated into QDS Model Version 2.1 where appropriate. Moving forward, NQF will regularly publish updates required by measure development input and based on public comments, at least semi-annually. The Health Information Technology Advisory Committee (HITAC) will also offer input regarding enhancements, modifications, and management of the QDS.
236.3	Mark Antman, American Medical Association	general	It is unclear what type of model is being presented for this data set. A data model typically defines the context of data and identifies the relationships among the data. However, for this data set it appears that there is no overarching conceptual model (schema) that defines the scope of the model. Additionally, the model (which most resembles a logical data model) does not have a consistent set of patterns (class/attribute or other). This can be seen in the definition of "care goal" where "care goal" is both the category and the element. It would be helpful to have a data structure diagram as it provides graphical notations which document data and their relationships, and the binding constraints. Moving forward, we suggest that the structure of the model be more clearly defined so as to make the model more understandable for potential users.	NQF agrees a logical data model is the most appropriate concept. QDS Model Version 2.1 modified some concepts (e.g., the category 'Physical exam finding' was changed to 'Physical exam' with data types consistent with other concepts). Other concepts will be modified to coincide with that approach, specifically the categories 'Care goal,' 'Encounter,' and 'Functional status.' Care goal and care experience are two concepts that require further definition and will be referred to the Health Information Technology Advisory Committee for direction.

No.	Org. Contact	Type of Comment	Comment	NQF Response
237	Mark Antman, American Medical Association	general	We have noticed that the "EHR Functional Model/HL7 Reference" column has been removed from the current version. We believe the information captured in the column is important and we recommend including it in future versions.	Thank you for your comment. The EHR Functional Model (EHR_FM / HL7) was used as a reference point from which to develop the QDS; however it does not address many of the issues NQF feels is required for the QDS.
237.1	Mark Antman, American Medical Association	general	It does not appear that there is 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 (eg, living will, advance care plan). We 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.	NQF believes Items such as durable power of attorney, living will, and advanced directives are managed with data type 'Patient characteristic' for the standard category 'Individual characteristic.' NQF invites further comment for managing 'Advance care plan.' A care plan is composed of a condition, or diagnosis, for which an intervention is planned and performed with a goal (an expected outcome) and an actual outcome. The individual components of a care plan can be managed with existing data types in the QDS model. A goal is a defined target or measure to be achieved in the process of consumer care. A typical goal is expressed as an observation scheduled for some time in the future with a particular value. A goal can be found in the plan of care (care plan). The plan of care (care plan) is the structure used by all stakeholders, including the consumer, to define the management actions for the various conditions, problems, or issues identified for the target of the plan. It is the structure through which the goals and care planning actions and processes can be organized, planned, communicated, and checked for completion. A time/date stamp is required.

No.	Org. Contact	Type of Comment	Comment	NQF Response
237.2	Mark Antman, American Medical Association	general	We note that there are still categories and data types that are the same, eg: "care goal". We suggest that for the purpose of clarity that the model avoids labeling data types the same as overarching categories.	NQF will develop over time, a graphic that illustrates that the model has a consistent set of patterns. The QDS Model Version 2.1 modifies some concepts (e.g., the standard category 'Physical exam finding' was changed to 'Physical exam' with data types consistent with other concepts). Other concepts have also been modified in the new version published in September 2010 to coincide with that approach, specifically, 'Encounter' and 'Functional status.'
237.3	Mark Antman, American Medical Association	Other	Finally, we note that there are inconsistencies throughout the table provided. For example, there are times when colons, ":", are used and other times when they are not. We suggest reviewing the document for internal consistency.	Thank you for your comment. NQF will review and make the necessary formatting changes.
238	Mark Antman, American Medical Association	medications	We recommend the addition of “medication options, counseling”	Thank you for your comment. Counseling is currently included in the 'Intervention' category and counseling regarding medication options can be addressed using the 'Interventions' category options.
240	Mark Antman, American Medical Association	medications	Data type appears to be missing: "to _____" (presumably “clinician” would be the object)	In the QDS Model Version 2.1, NQF corrected the text and changed it to 'Communication from patient to provider.'
241	Mark Antman, American Medical Association	condition/ diagnosis/ problem	We recommend the addition of “or a clinical feature which is treated, monitored, worked-up, or impacts the encounter or length of stay”	In the QDS Model Version 2.1, NQF modified the text to "or a clinical feature which is treated, monitored, evaluated, or impacts other treatment or venues of care (e.g., encounters or lengths of stay)."

No.	Org. Contact	Type of Comment	Comment	NQF Response
242	Mark Antman, American Medical Association	device	Directly after: (...or prevention of disease in man or animals) we recommend the addition of “monitoring, or provide palliative care...”	In the QDS Model Version 2.1, NQF modified the language based on the definition from the Food and Drug Administration (FDA), Department of Health and Human Services: A device is “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment [monitoring or to provide palliative care], or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.”
243	Mark Antman, American Medical Association	device, adverse event	Directly after: (... and those that require intervention to prevent permanent impairment or damage) we recommend the addition of “or that impacts treatment, care-plan, or encounter.”	In the QDS Model Version 2.1, NQF modified the 'Device, adverse event' language as follows: "In the instance of a quality measure, a device adverse event is an unexpected or dangerous reaction to a device. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling, those that require or prolong hospitalization, and those that require intervention to prevent permanent impairment or damage or that require specific treatment, care plan or encounter." This phrase is added to other 'adverse event' data types to be consistent across definitions, as requested in comment 307.
244	Mark Antman, American Medical Association	device, allergy	Directly after: (e.g., implanted device) we recommend the addition of “or that impacts or alters treatment, care-plan, or encounter.”	In QDS Model Version 2.1, NQF modified 'Device, allergy,' language by adding "or that impacts or alters treatment, care plan, or encounter" after “… e.g., implanted device…”

No.	Org. Contact	Type of Comment	Comment	NQF Response
245	Mark Antman, American Medical Association	device, applied	Directly after: (...designed to treat, monitor, or) we recommend the addition of “or provide palliative care.”	In the QDS Model Version 2.1, NQF modified the 'device, applied' definition by adding "or that impacts or alters treatment, care plan, or encounter" after “…designed to treat, monitor…”
246	Mark Antman, American Medical Association	diagnostic study, adverse event	Directly after: (...lead to congenital anomaly…) we recommend the addition of “are fatal or life-threatening, or that impact treatment, care plan or encounter”.	In the QDS Model Version 2.1, NQF modified the 'Diagnostic study, adverse event' language by adding "are fatal or life-threatening" and "require specific treatment, care plan or encounter." These phrases were added to other 'adverse event' data types to be consistent across definitions, as requested in comment 307.
247	Mark Antman, American Medical Association	encounter, encounter	Directly after: (...face-to-face visit to a clinician’s office...) we recommend the addition of “or any electronically remote interaction with a clinician.”	In the QDS Model Version 2.1, NQF modified the 'Encounter' language by adding "or any electronically remote interaction with a clinician" after “…face-to-face visit to a clinician's office...”
248	Mark Antman, American Medical Association	laboratory test, adverse event	Directly after: (...those that require or prolong hospitalization,...) we recommend the addition of “or that alter treatment or care plan,”	In the QDS Model Version 2.1, NQF modified the 'Laboratory test, adverse event' language by adding "or that require specific treatment, care plan, or encounter." This phrase was added to other 'adverse event' data types to be consistent across definitions, as requested in comment 307.
249	Mark Antman, American Medical Association	procedure, intervention	Comment: typically, such actions as “dressing changes, placement of antithrombotic devices, and/or insertion or removal of intravascular access” are all coded as procedures and considered as such. Although their purpose may be interventional, the action is procedural.	Thank you for your comment. Intervention here is intended to specify activities that can be performed by a clinician or a patient or surrogate as part of routine care whether or not the activity is billable to a third party. Specifically with respect to antithrombotic devices, Greenfield filters are reimbursable and are inserted in controlled settings and therefore are procedures. Placement of TED hose as antithrombotic devices are listed as an intervention, because they can be placed by clinicians or educated patients with equal effect (refer to 'Intervention' definition in the response to comment 230).

No.	Org. Contact	Type of Comment	Comment	NQF Response
250	Mark Antman, American Medical Association	physical exam	Directly after: (auscultation (listening)...) we recommend the addition of “visual examination”	In the QDS Model Version 2.1, NQF modified the 'Physical exam' language by adding "visual inspection" after “…auscultation (listening)...”
251	Mark Antman, American Medical Association	individual preference	Directly after: (language, religious,...) we recommend the addition of “personal or informed choice, “	In the QDS Model Version 2.1, NQF modified the 'Patient preference' language by adding "personal or informed choice" after “…language, religious, ...”
252	Mark Antman, American Medical Association	procedure, adverse event	Directly after: (fatal, life-threatening...) we recommend the addition of “are fatal or life-threatening, or that impact treatment, care plan or encounter”.	In the QDS Model Version 2.1, NQF modified the 'Procedure, adverse event' language by adding "or that require specific treatment, care plan or encounter." This phrase was added to other 'adverse event' data types to be consistent across definitions, as requested in comment 307.
253	Mark Antman, American Medical Association	system characteristic	Directly after: (health information technology structures...) we recommend the addition of “, or access to care systems...”	In the QDS Model Version 2.1, NQF modified the 'System characteristic' language by adding "or access to care systems" after “…health information technology structures...”
254	Mark Antman, American Medical Association	transfer of care	Directly after: (whereby there is an exchange of patient information...) we recommend the addition of “permanent or temporary medical devices or equipment...”	In the QDS Model Version 2.1, NQF modified the 'Transfer of care' language by adding "permanent or temporary medical devices or equipment" after “…whereby there is an exchange of patient information...”
257	Crystal Kallem, AHIMA	physical exam	Our members do not commonly see physician orders for physical exams. Does this data type also encompass physician (or other licensed care provider) requests for consultation, or requests to clear a patient for surgery? Please consider incorporating additional examples to help clarify the definition of this QDS data type.	NQF will retain 'Physical exam, ordered' in the QDS Model Version 2.1 and invites further comment. The data type is expected to be used to identify orders such as "vital signs, frequency every x hours), or "pedal pulse check, frequency every 15 minutes for x hours." NQF also invites comment about the need for a data types 'Physical exam, scheduled,' and 'Encounter, scheduled.' Neither is added in the current version pending comment.

No.	Org. Contact	Type of Comment	Comment	NQF Response
258	Crystal Kallem, AHIMA	condition/ diagnosis/ problem	Similar to the “condition/diagnosis/problem” standard category, the “symptom” standard category should also include data types for “symptom, inactive” and “symptom, resolved”. AHIMA recommends adding these two data types to support appropriate management of symptoms as part of an interdisciplinary problem list.	In the QDS Model Version 2.1, NQF modified the 'Symptom' category by adding "Symptom, inactive and Symptom, resolved."
259	Lisa Latts, WellPoint	general	There is inconsistent use of consumer vs. patient throughout the document. If these are not interchangeable, please provide an explanation of the differences.	Most current measures address the individual for whom a provider has given care; therefore, the term 'patient' has been used in the QDS Model Version 2.1. Going forward, NQF will address a definition for 'consumer.' NQF invites further comment on the definitions for 'patient' and 'consumer,' as well as comments on using the term 'consumer' in category and data type titles.
260	Lisa Latts, WellPoint	Care experience	This definition seems very broad and includes concepts about patient-centered care and shared decision-making that aren’t defined elsewhere. Will all things related to patient-centered care or shared decision be classified as care experience? Also, care experience has two data types: patient care experience and provider care experience. However, the larger definition for care experience only describes patient care experience – it does not align with items in the MCPSS or the definition of provider care experience.	NQF agrees with removal of the Medicare Contractor Provider Satisfaction Survey (MCPSS) as part of the definition for 'Provider care experience.' The MCPSS "is designed to collect quantifiable data on provider/supplier satisfaction with the performance of Medicare FFS [Fee for Service] contractors" [Available at: http://www.cms.gov/MCPSS/]. In the QDS Model Version 2.1, NQF added "Provider care experience is expected to determine the provider's experience with availability of resources (e.g., scheduling, equipment, space, consumables such as medications, etc.)" to the 'Provider care experience' definition. NQF also modified the data type 'Individual characteristic, provider characteristic' to include more provider characteristic examples (see comment 268).

No.	Org. Contact	Type of Comment	Comment	NQF Response
261	Lisa Latts, WellPoint	Care goal	It is unclear what is needed for the quality data type, in part because the definitions are identical for the standard category and the quality data type. Also, this category is inconsistent with other data elements. There is nothing about the “action” – should it be documented? If so, should there be a time/date stamp? Lastly, is it appropriate for the care plan requirements to be listed in this category, or should care plan be its own data type?	In the QDS Model Version 2.1, NQF has modified 'Care plan' category to include a description of how existing data types can apply to a care plan.
262	Lisa Latts, WellPoint	Condition/ diagnosis/ problem	The definition mentions chronic conditions but not acute. Are acute conditions included in this category?	In the QDS Model Version 2.1, NQF modified the definition of the category 'Problem, Diagnosis, Condition' to include the italicized text as follows: "A problem, diagnosis, or condition is a scientific interpretation of result, assessment, and treatment response data that persists over time and tends to require intervention or management. It is used to guide planning, implementation, treatment, and evaluation. A problem or condition includes, but is not limited to acute, intermittent or chronic conditions, diagnoses, or symptoms, functional limitations, or visit- or stay-specific conditions."
263	Lisa Latts, WellPoint	encounter, encounter	It is confusing to have the same definition for standard category and data type. It would seem appropriate to have more detailed information in the data type description that outlines what specifically should be documented. Also, should there be descriptions of different types of encounters?	In the QDS Model Version 2.1, NQF added specific data types for the category 'Encounter.' These data types include: 'Encounter, ordered' and 'Encounter, performed.' The category 'Negation rationale' was also updated to include the data type 'Encounter, not done' to allow measures to include exclusion criteria for valid reasons that an encounter did not occur.
264	Lisa Latts, WellPoint	functional status	This category does not follow the same definition and quality data type classifications as other categories. Wouldn’t functional status follow the same template as physical exam, with data types such as ordered, performed, results, findings, etc.?	In the QDS Model Version 2.1, NQF added the following data types to the category 'Functional status' because, for the purpose of clinical decision support and care plans, more process oriented steps are required: 'Functional status, ordered,' 'Functional status, performed' and 'Functional status, result.

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265	Lisa Latts, WellPoint	individual characteristic, provider characteristic	The definition mentions facilities; however, there is not a definition or data type for facilities.	The term 'facility' was used incorrectly. NQF replaced the term 'facility' with 'organization' (e.g., hospital, ambulatory surgical center, physician office, home care provider, durable medical equipment provider) in the 'Individual characteristic' category and data types, as well as other relevant categories and data types. The intent was to indicate characteristics of an individual provider (i.e., practitioner of care) and/or organization of care.
266	Lisa Latts, WellPoint	individual characteristic, patient characteristic	The definition includes comfort measures as one of the types of data that would fall under this type – could NQF please provide some examples of comfort measures?	In the QDS Model Version 2.1, NQF removed the term 'comfort measures only' from 'Patient characteristic.' The term, 'comfort measures only' was intended to indicate a desire by a consumer (or patient) to receive no aggressive treatment and only measures to avoid pain or discomfort, i.e., a terminal illness related advance directive. Specific comfort measures are not indicated, as the statement is intended to cover patient care preferences. Such preferences are more appropriately covered by 'Preference, patient preference.'
268	Lisa Latts, WellPoint	individual characteristic, provider characteristic	Please provide examples as to what would be included in this data type.	Specific information about the clinician provider or the organization caring for the consumer. Examples of provider characteristics include: degree, education, training, clinical experience, clinical privileges (which are based on experience), as well as gender, race, ethnicity, language(s) spoken, age range, practice open or closed, practice types, location, and other demographic characteristics. Any of these could be used in measures, as in a risk adjustment algorithm. A time/date stamp is required.

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269	Lisa Latts, WellPoint	intervention, procedure	The first sentence of this definition is too broad, and appears to describe actions that are not applicable to the healthcare setting. Also, the examples included for this standard category are the same as the examples listed for Procedure. Please make sure that these two categories clearly differentiate which actions should fall under Intervention and which should fall under Procedure.	Intervention here is intended to specify activities that can be performed by a clinician or a patient or surrogate as part of routine care whether or not the activity is billable to a third party. Specifically with respect to antithrombotic devices, Greenfield filters are reimbursable and are inserted in controlled settings and therefore are procedures. Placement of TED hose as antithrombotic devices are listed as an intervention as they can be placed by clinicians or educated patients with equal effect (refer to 'Intervention' definition in comment 230).
270	Lisa Latts, WellPoint	medication, adverse effects	The adverse effect data type for medication only covers side effects that occur when the correct medication is administered as prescribed. Shouldn't there also be an adverse events type that covers medication errors, etc.?	NQF invites further comment regarding the management of the data types 'adverse event,' 'adverse effect,' 'intolerance,' and 'allergy.' A number of definitions exist but EHR implementations are variable and consensus on a clear standard of practice for documentation is required. The QDS Model has not been modified to include 'adverse event' at this time for any other category outside of 'Medication.' 'Adverse effect' was included to cover the effect of a medication when prescribed appropriately. Measure logic could be applied to existing QDS data type to identify some medication errors, e.g., comparing a medication order (with attributes of timing, dose, route, frequency) with expected total daily dose or actual administered total daily dose.

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271	Lisa Latts, WellPoint	medication, administered	It is unclear what is meant to be captured by this field. Please provide some clarification as to what should be documented in order to demonstrate whether or not "this fact conforms to the order." Does this mean that the medication was administered according to the physician's order?	In the QDS Model Version 2.1, NQF modified the 'Medication, administered' definition to read: "A record by the care provider that a medication actually was administered. Appropriate time/date stamps for all medication administration are generated." For the purpose of quality measures, 'Medication, administered' should provide the date and time of administration of any given medication. To determine that the medication was administered according to the physician's order requires the measure logic to indicate the attributes of timing, frequency, dose and route are the same for the medication order (one data type) and the medication administered (a different data type).
272	Lisa Latts, WellPoint	medication history	Doesn't this also need a time/date stamp?	In the QDS Model Version 2.1, NQF has indicated that all QDS data types need a date/time stamp. Please reference response to comment 225.
273	Lisa Latts, WellPoint	symptom	This category is not consistent with similar categories (eg, Diagnosis). Should there be a symptom history data type?	In QDS Model Version 2.1, NQF modified the 'Symptom' category by adding 'Symptom, inactive' and 'Symptom, resolved' to be consistent with other categories, such as 'Condition, Diagnosis, Problem.'
274	Rebecca Zimmermann, AHIP	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.

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275	Debra Ness, Consumer-Purchaser Disclosure Project		We would like to express some concern over the inclusion of the "provider care experience" data type being listed within the category of "care experience." We believe that the term "care experience," in the context of a data type, should refer solely to measuring the experience of patients and their family or other caregivers in receiving health care. Language matters, and it has taken a strong advocacy effort to shift the framework away from discussing patients' experiences with care in the context of "patient satisfaction" and squarely into the realm of understanding how do patients experience their care, and how can providers translate that understanding into developing a more patient-centered delivery system that improves health outcomes, compliance with treatment protocols, etc. At the same time, we do acknowledge the importance of knowing providers' experience with structures, processes, and outcomes that they face in their practice environment. The difference is that whereas "patient experience" is now inextricably linked with how patient-centered one's care is or was, provider experience – we feel – is more about provider's satisfaction with their workplace and the delivery environment, which falls more readily into the category of efficiency. Much has been written recently about providers' frustration over the amount of time they spend on administrative work versus on direct patient care, and understanding how that frustration/experience feeds into the delivery system as a whole is crucial. We feel, however, that this is a workforce issue rather than a direct quality of care issue, and therefore it should be distinct from patient clinical care experience. We suggest that a data element that relates to providers' satisfaction with structures and processes be included in a different "standard category" related to efficiency issues, and	Thank you for your comment. In the QDS Model Version 2.1, NQF updated the definition to add "Provider care experience is expected to determine the provider's experience with availability of resources (e.g., scheduling, equipment, space, consumables such as medications, etc.)." NQF invites further comment regarding the effect of including provider care experience in the same category as patient care experience.

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			should be focused on data elements that will specifically enable stakeholders' understanding of providers' experiences in using HIT. One of the major goals of implementing HIT is to streamline administrative processes and create a care environment where providers have more opportunity to work with their patients. Thus, we feel that the related QDS standard category should be aimed at collecting data on the extent to which integration of HIT into a care setting has improved administrative efficiencies and alleviated providers' frustrations regarding spending significant amounts of time on paperwork versus on direct patient care, which is what we surmise the "provider care experience" data type is trying to assess.	

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277	Debra Ness, Consumer-Purchaser Disclosure Project	general	Critical to understanding patients' needs and health status is knowing whether that patient is the caregiver for a chronically ill family member. Research, as well as anecdotal evidence, has shown that the stress of being the primary caregiver for a sick family member can have a significant impact on a patient's own well-being and ability to comply with treatment protocols. We recognize that caregiver status would likely be considered a data element, and that the document from the HITEUP on data elements has not been released for public comment yet, we still feel it is important to signify in this document in which standard category such an important data element would be captured. From our perspective there are two categories that could potentially capture this data element: "Patient Characteristic" and "Risk Category/Assessment." We strongly urge NQF to clearly delineate in which category this critical element would fall. Our preference would be to include it in the "Patient Characteristic" data type, and expand the description to read "Specific information about the patient, including demographics and whether or not the patient is the primary caregiver for a chronically ill patient."	In the QDS Model Version 2.1, NQF modified the language in 'Patient characteristic' to include, 'Patient characteristics include details about caregiving, and whether or not the patient is the primary caregiver for a chronically ill patient. Standardization of caregiving characteristics will be helpful to specify the distinct attributes.' It is understood that the industry is still currently discussing how to best handle the concept of 'intervention' and the concept is expected to evolve.

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278	Debra Ness, Consumer-Purchaser Disclosure Project	general	The Consumer-Purchaser Disclosure Project is very appreciative of the work being conducted by the Health Information Technology Utilization Expert Panel (HITUEP) to develop a model of standardized data elements that can be used by measure developers and EHR vendors to enable the collection of quality data electronically, as the quality measurement enterprise transitions to an EHR-based platform. The work of the HITUEP is critical to ensuring that measure categories and elements are standardized in a way that allows for automated collection and use of the data that will enable comparisons of quality of care across providers and systems. We thank the National Quality Forum for providing this opportunity to comment on the Quality Data Set (QDS) in general, and on the standard categories and quality data types in particular.	Thank you for your comment.
279	Jason Mitchell, AAFP	general	The "nouns" of quality measurement and improvement must be clearly delineated and consistently defined and applied. Measure developers deal with a core set of these "nouns". Agreement of these "nouns" across measures will simply the understanding and application of developed measures. These "nouns" are typically identified as "objects" or "classes" in informatics circles. "Data" is typically considered to represent the discrete values of the "properties" contained within a "class" or "object". This creates a fundamental disconnect in the "Quality Data Set". The QDS is not a list of "properties" and their values. It is a list of "objects" or "classes". Currently developed measures seem to have been used to define the objects required to build them. The QDS model must reach beyond established measures and encompass a platform for the development of the	Thank you for the comment. NQF developed the QDS in a transparent, collaborative process intentionally including a very wide range stakeholder domains. The QDS is identified as a model for the very reasons expressed in the comment. The data types are not discrete values as noted; they are classes. These classes are applied and instantiated as objects in the eMeasure / Health Quality Measure Format (HQMF). Individual class attributes (referred to as "data type specific attributes") are defined in the process of eMeasure development referencing available data in HL7 standards. The QDS was created with the express consideration of information required for future measurement. The model was tested by a careful review of over 500 previously NQF-endorsed measures. The model has already evolved based on based on measure retooling efforts using the eMeasure HQMF and it will continue to evolve with the direction of NQF's new standing committee, the Health Information Technology Advisory Committee (HITAC).

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			quality measures of the future, considering pending advances in clinical data collection and analysis. The QDS represents the "dictionary" of quality measurement and improvement. Anything that is not contained in the dictionary cannot be expressed in a consistent and universally understandable way. This also implies that when a "word" in the dictionary changes in meaning or usage, or is completely removed, every previously existing sentence that contains that word changes in its expressed meaning. Such changes could have extensive unintended consequences. Once this QDS goes into widespread usage, any change in its content could invalidate previously developed measures. Versioning could mediate this effect, but a version a month is likely to be more than most measure developers and users could stand. Though the "objects" of the QDS are useful, further delineation of the "properties" of those "objects" must be undertaken by NQF and the constraints on the values that could represent those "properties" must also be established. This is getting into the weeds, and we are not yet ready for such activity, but a roadmap for this work must be expressed from the beginning of the journey if NQF expects others to get on the bus. The linkage between clinical practice guidelines, quality measures, and clinical decision support require concepts to be shareable across these domains. Some measures are about populations, some are about individual patients, some are about providers. These concepts to not appear in the QDS. Similarly, the distinction between an "intervention", "laboratory test", "diagnostic study", "medication", "procedure", or	All modifications will be the result of a collaborative and transparent process. Any changes will be archived and elements no longer useful will be documented with clear incorporation of those concepts into their new concepts respectively.

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			"substance" may not be as clear cut as originally perceived. These concepts overlap significantly. Though they are common parlance in clinical medicine, are there underlying "concepts" that would be more appropriate for a "model", realizing that the model must represent, but is not "real life". Thanks for the opportunity to comment. We look forward to continuing to work with you on refining and applying this important work.	
298	Joseph Drozda, American College of Cardiology	medications	Medications need to add a classification for "ineffective". Perhaps it only occurs in EP but I am sure that has to occur in other areas (such as oncology). Many times medications are discontinued because they were ineffective (antiarrhythmic therapy, antibiotics, anti-chemotherapy medications, etc. By having that listing it can help when you need to make another therapeutic decision.	Thank you for your comment. NQF invites further comment regarding ineffective medication. The current QDS model should allow a measure developer to specify as part of the measure logic to determine if a medication is effective or not effective.
300	Joseph Drozda, American College of Cardiology	condition/ diagnosis/ problem	Expanded criteria for problem list (active, inactive, resolved) will not be sufficient for decision support. For instance, the need to support ambiguity and negation, i.e. this patient does not have CAD. Additionally, problems, especially signs and symptoms, morph into diagnoses, i.e. chest pain into acute coronary syndrome. However, this can be resolved through HL7 balloting.	Thank you for your comment. The ability to indicate negation of a condition and avoid ambiguity requires further work in standards development. NQF will consider possible changes in the future as standards are further refined.
301	Joseph Drozda, American College of Cardiology	general	It would be a good idea to be able to attribute/link problems to providers. That is a recurrent problem when trying to attribute quality outcomes to individuals/groups. For instance, a seventy year old women with atrial fib, CAD and hypertension would still need a pap smear, mammogram and colonoscopy. A cardiologist should not be held responsible for her routine health care maintenance but should for her cardiovascular diseases.	Thank you for your comment. The measure developer can specify a type of provider within the logic to manage attribution.

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302	Joseph Drozda, American College of Cardiology	diagnosis, risk of	Data types need to correspond precisely to the clinical concept. Three of the data types of this general category of "condition / diagnosis / problem" are consistent with the clinical concept (diagnosis, active; diagnosis, inactive; diagnosis, resolved). However, 2 of the suggested data types are not congruent with the clinical concept of this general category. “Diagnosis, risk of” is not a singular data concept, but is an aggregation of multiple data inputs. It also is unclear how this differs from "risk category / assessment”. In the interest of simplification, I would recommend that this data type be deleted.	In the QDS Model Version 2.1, NQF deleted 'Diagnosis, risk of' because it is a compilation of multiple data inputs, each of which can be identified from other data types.
302.1	Joseph Drozda, American College of Cardiology	diagnosis, family history	Data types need to correspond precisely to the clinical concept. Three of the data types of this general category of "condition / diagnosis / problem" are consistent with the clinical concept (diagnosis, active; diagnosis, inactive; diagnosis, resolved). However, 2 of the suggested data types are not congruent with the clinical concept of this general category. One of them was “diagnosis, family history” does not reside in the same clinical context as this general category - it should be a separate general category, "family history".	Thank you for your comment. NQF will consider moving 'Diagnosis, family history' to its own category in a future version, based on public comments. 'Risk category / assessment' has a different meaning and will remain in its current category.
303	Joseph Drozda, American College of Cardiology	physical exam, ordered	The data type “physical exam, ordered” should be deleted. A physical exam isn’t “ordered” like other tests.	Physical exam, ordered' will be retained, as noted in the response to comment 257.

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304	Joseph Drozda, American College of Cardiology	general	"There is a lack of clarity among the various categories for diagnostic tests and therapies, with much potential for overlap. In particular, the term ""procedure"" spans the concepts of ""device"" ""diagnostic study"" and ""intervention"", and devices can be used in both diagnostic studies and intervention. The following data types therefore need to be rethought: · Device · Diagnostic Study · Intervention · Procedure I would suggest removing the word ""procedure"" completely, and creating a simpler schema with the following contexts: · Diagnostic test / study (exclusive of things done where no treatment is administered) · Treatment / therapy / intervention I would also have a completely separate category for devices, but make the device concept specific to implanted devices (things left in the body following a procedure): · Implanted devices"	NQF will consider modifications as suggested by commenter in a future version of the QDS. Refer to the response to comment 230.

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306	Joseph Drozda, American College of Cardiology	device, adverse event	The only issue I have relates to the language of adverse events especially related to devices. Specifically "unexpected or dangerous" reaction to a device. I am conflicted regarding this as I wonder how to classify an event in a patient who has a normally functioning ICD with appropriately programmed ATP that fails to convert a hemodynamically tolerable rhythm, and in-fact, accelerates it to VF resulting in a shock. Acceleration of stable VT to VF is a "dangerous" event and potentially life threatening but entirely within the spectrum of potential outcomes of arrhythmia management in this scenario. It is not unexpected. It is clearly undesirable but I am not certain it is an adverse event. Without meaning to trivialize it, would an unexpected increase in IQ after an ICD be considered an adverse event? The term begs a negative connotation and thus it seems to me the conjugate should perhaps be AND, making the definition "unexpected and dangerous" or "unexpected and undesirable". Additionally the definition does not take into consideration actual device performance. In the scenario proposed above, this is not a product malfunction but an outcome in a normally functioning device. I will defer to your collective wisdom as to whether there is any validity to pursuing this line of thinking.	In the QDS Model Version 2.1, NQF retained the language 'unexpected or dangerous' to apply unexpected and expected events to those that may be dangerous. NQF invites additional comment.
307	Joseph Drozda, American College of Cardiology	diagnostic study, adverse event	"In some cases the definition of serious adverse events varied. The definition for ""diagnostic study, adverse event"" (page 9) seems to differ from the other categories (e.g. ""device, adverse event"", page 8).	In the QDS Model Version 2.1, NQF defined 'adverse event' consistently across data types.

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308	Joseph Drozda, American College of Cardiology	diagnostic study	The term "clinical laboratory"" is not defined. Its confusing because some testing centers may refer to themselves as a ""laboratory"", for example the ""EEG laboratory"". If the phrase ""clinical laboratory"" is meant to be restricted to facilities that perform testing on samples of human blood, tissue or other substance from the body, then that should be more explicit.	In the QDS Model Version 2.1, NQF restricted the 'Diagnostic study' definition to include "organizations that perform testing on samples of human blood, tissue or other substance from the body." The intent is to capture tests for human blood, tissue, or other body substances as laboratory tests.
309	Joseph Drozda, American College of Cardiology	general	The distinction between "adverse event" and "intolerance" is poorly defined, in my opinion.	It is understood that in practice, 'intolerance', 'allergy', and 'adverse events' are often intermingled in the 'allergy list'. NQF requires further clarification from industry to more clearly differentiate these concepts.
310	Joseph Drozda, American College of Cardiology	medication, allergy	The "medication, allergy" data type definition states that the allergy "recurs on re-exposure to the offending drug." I'm not sure that this statement offers much useful information because when a possible allergy is identified re-exposure is avoided. It should be clarified that recurrence on re-exposure is not required to determine the presence of an allergy, but rather is simply a characteristics of an allergy.	In the QDS Model Version 2.1, NQF modified the 'Medication, allergy' text to include the phrase: "Recurrence on re-exposure is not required to determine the presence of an allergy, but rather is simply a characteristic of an allergy."

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311	Joseph Drozda, American College of Cardiology	procedure, performed	"Procedure, performed" quality data type (page 22): examples of procedures performed include "...assisted ambulation..", etc. However these same activities were previously defined as "interventions" (page 13). Furthermore it is specifically stated that "intervention specifically excludes procedures..." (page 13) and that "procedure is distinct from intervention" (page 22). So there seems to be a problem of the logic here. Are assisted ambulation and the like procedures, or interventions? Because apparently they cannot be both.	NQF recognizes the potential overlap of categories of Intervention, Procedure, or Diagnostic test. The distinction is clarified in modification to the text in each of the three definitions. NQF will enhance the definition of Intervention as indicated in the response to comment 230.