



May 19, 2011

National Quality Forum
Attention: Quality Data Model Review Panel
601 13th Street, NW
Suite 500 North
Washington, DC 20005

RE: 60-day Public and Member Comment – Quality Data Model

Dear Quality Data Model Review Panel:

The Alliance for Nursing Informatics (ANI) is pleased to submit written comments to the National Quality Forum (NQF) on the Quality Data Model (QDM). We applaud your efforts to obtain public input as you consider this important topic and we appreciate the work completed to date.

The [Alliance for Nursing Informatics](#) (ANI) advances NI leadership, practice, education, policy and research through a unified voice of nursing informatics organizations. We transform health and health care through nursing informatics and innovation. ANI is a collaboration of organizations that represents more than 5,000 nurse informaticists and brings together 28 distinct nursing informatics groups globally. ANI crosses academia, practice, industry, and nursing specialty boundaries and works in collaboration with the nearly 3 million nurses in practice today.

ANI recognizes the importance of having an information model that clearly defines concepts used in quality measures and care delivery to enable automation of structured data capture in health information technology (HIT). The QDM version 3.0 provides the potential for more precisely defined, universally adopted electronic quality measures to automate measurement through the use of electronic health information captured as a byproduct of care delivery. By defining the Quality Data Model, it will now be possible to capture performance data as part of the care process and provide immediate information feedback and decision support to improve care.

General Comments

The specification refers to IFMC as the subcontractor secured to develop a Measure Authoring Tool. However, the acronym IFMC is not explicitly spelled out. Providing the full name for the acronym will enhance understanding of the relationship between the QDM and the Measure Authoring Tool.

As stated in the specification, the QDM is intended to enable automation of data contained in EHRs, personal health records, and clinical applications. However, data from administrative and financial applications are critical to evaluating NQF-endorsed measures related to nurse staffing. Specifically, data from these systems are instrumental in calculating the percentage of productive nursing hours worked by registered nurse (RN) staff with direct patient care responsibilities. ANI suggests the addition of administrative and financial applications to the specification, which will



more adequately reflect existing NQF-endorsed measures. The QDM must support both clinical and administrative concepts associated with performance measurement and improvement.

As written within the specification, the “QDM is a model of information used to express patient, clinical, and community characteristics.” However, QDM’s vision is to support measurement and improvement efforts across all aspects of health and healthcare delivery. For this reason, ANI suggests that the patient, clinical, and community characteristics be changed to “care delivery and population health characteristics”, taking into consideration all aspects of care delivery, including the social and economic well-being of the population. This is an important aspect of QDM’s evolution and is aligned with the NQF National Priorities Partnership.

QDM Concepts

Within the QDM specification, there are repeated references to “clinical” concepts. A definition of clinical concepts should be added to eliminate any ambiguity in interpretation and use of the QDM. This is important because performance measurement involves the “person being measured” as well as the “healthcare delivery provided.” Healthcare delivery is not restricted to “clinical” concepts. Healthcare delivery involves administrative and financial concepts related to the operational management of care. As an example, staffing and resource utilization are system factors and not necessarily considered “clinical” concepts. However, these factors are an important part of performance measurement. This is reflected in the existing NQF-endorsed measure “Practice Environment Scale - Nursing Work Index (composite and five subscales).”¹

There is a QDM concept labeled “transfer”² to support continuity and coordination of care. In addition to transfer, care coordination functions typically involve a discharge from one location (hospital) and an admission to another location (long-term care setting or agency). It is not clear how these concepts are handled within the QDM.

The concept of a “goal” or “expected outcome” is a critical factor when planning and providing care. Defining and monitoring goals are essential in preventing potential problems, resolving a currently existing problem, or maintaining or enhancing a present status or level of functional ability. Goals are subsumed within the QDM concept “characteristics.” Given the critical importance of defining and monitoring goals within care delivery, ANI recommends that goals should be structured discretely to support future measures related to the planning and coordination of care. Clear, concise communication and monitoring of goals are essential to the plan of care and should be defined as discrete concepts along with the QDM concepts of condition/diagnosis/problem and intervention.

QDM States

The QDM state of “assigned” should be added to the QDM states of action to support existing NQF measures related to nurse staffing.

¹ National Quality Forum (NQF)-Endorsed Standards, 2009.

² Transfer refers to the different locations or settings a patient is released to, or received from, to ensure the coordination and continuity of health care (QDM, April 2011).



QDM Attributes

The QDM attribute related to the “actor” also should specify data derived and recorded by consumers to reflect all aspects of care delivery related to self care management.

Concepts Accounting for Care Coordination

As the healthcare system has expanded over the past 40 years, many health professionals provide care in accordance with their associated scope of practice standards. To this extent, the references to physician should be expanded to include provider or healthcare professional. This is of particular importance in care coordination. For example, nurses who work in long term care settings (e.g., home care, skilled nursing, etc.) make referrals to social workers and community support services. In addition, the communication between home care nurses and primary care providers during initial visits to long term care settings plays a significant role in prevention of re-admissions. During transitions from acute-to-long-term care, nurses reconcile symptoms, problems, interventions, and diagnoses. For this reason, the state of “reconcile” should be added as a state under the concept “symptom.”

Definitions

Components of the definition provided for “characteristics” and “symptom” overlap with the definition for condition/diagnosis/problems. Specifically, the definition of characteristics includes mental health issues, adherence issues, coping issues, grief issues, and substance use issues. These labels are considered diagnoses within the scope of nursing practice. A nursing diagnosis is a clinical judgment about individual, family, or community experiences and responses to actual or potential health problems and life processes.³ ANI recommends that greater clarity between the definition of characteristics and condition/diagnosis/problems be provided.

The definition for condition/diagnosis/problems references “scientific interpretation of a result, assessment, and treatment response data.” Many times, consumers/patients report problems that become part of the problem list but are not scientifically interpreted based on a result or assessment by a provider. The definition of condition/diagnosis/problems should take into consideration consumer- and patient-centered care models whereby patient problems are recorded and monitored by providers and/or consumers in self care management.

The definitions for “environmental location” and “facility location” are not mutually exclusive. As an example, home could be considered an environmental location (patient developed chest pain at home) and also a facility location (the nurse is providing care during a home visit).⁴ In addition, it is not clear whether “facility location” is actually referencing “care provision location”. An unambiguous label is needed to differentiate the concepts related to location.

³ North American Nursing Diagnosis Association (NANDA), 2009.

⁴ Using the term “home” in this example is not intended to narrow the focus or be exclusive of other settings.



Summary

ANI appreciates the opportunity to submit these comments. Again, we thank the NQF for soliciting public input to help inform the review of the QDM. Please contact us at any time for further discussion of the comments offered here.

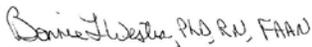
Nurses are critical members of the interdisciplinary healthcare team and are essential to the success of organizations as they continue to leverage the data and information contained in EHRs. The nursing profession performs an instrumental role in the key areas of patient safety, change management, design, and usability of systems as evidenced in quality outcomes, enhanced workflow, and user acceptance. These areas highlight the value of these knowledge-based workers and their role in the adoption of HITs, with greater integration across systems to deliver higher quality clinical applications in healthcare organizations.

On behalf of ANI, we thank the NQF for its ongoing attention to such an important public policy issue. ANI appreciates the opportunity to contribute to your deliberations. Finally, ANI again thanks you for inviting public comments. Please contact us at any time for further clarification of the issues we have raised.

Sincerely,



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The Alliance for Nursing Informatics (ANI)

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