CDM Implementation Forum
Thursday, October 7, 2015

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The National Patient-Centered Clinical Research Network

§ 170.315(a)(12) Smoking status p.67

- Laudable to liberalize the use of SNOMED CT codes to represent smoking status beyond the 8 codes used for 2014 edition certification criteria
- Problem that only those 8 codes are permissible for representing smoking status in the Common Clinical Data Set and for electronic transmission in a summary care record.
- The premise that any other smoking status code could be mapped to one of those 8 (as stated in the preamble) is erroneous.
    - Example: For instance, SNOMED 266920004, "trivial cigarette smoker (less than one cigarette/day)" is not a child, in the SNOMED hierarchy, of any of the 8 smoking-related codes required in the 2014 edition certification rule.
- Clarify that this refers to tobacco smoking status, rather than information on the smoking of other substances, since the intent of this criterion appears to be tobacco-specific.
- The Committee recommended a different and shorter (2 questions) measure for tobacco use and exposure than the one previously established as the standard for EHR certification.
- Shorter seems better, even if it requires making a change

https://www.healthit.gov/archive/archive_files/HIT%20Standards%20Committee/2015/2015-05-20/HITSC_SSWG_Cert_Rule_2015-05-20_Revised.pdf

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Topic 1

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The 15 PCORnet CDM Domains, v3.0

CONDITION v2.0
A condition represents a patient's diagnosed and self-reported health conditions and diseases. The patient's medical history and current state may both be represented.

DEATH v3.0
Reported mortality information for patients.

DEATH_CAUSE v3.0
The individual causes associated with a reported death.

DEMOGRAPHIC v1.0
Demographics record the direct attributes of individual patients.

DIAGNOSIS v1.0
Diagnosis codes indicate the results of diagnostic processes and medical coding within healthcare delivery.

DISPENSING v2.0
Outpatient pharmacy dispensing, such as prescriptions filled through a neighborhood pharmacy with a claim paid by an insurer. Outpatient dispensing is not commonly captured within healthcare systems.

ENROLLMENT v1.0
Enrollment is a concept that defines a period of time during which all medically-attended events are expected to be observed. This concept is often insurance-based, but other methods of defining enrollment are possible.

ENCOUNTER v1.0
Encounters are interactions between patients and providers within the context of healthcare delivery.

HARVEST v3.0
Attributes associated with the specific PCORnet datamart implementation

LAB_RESULT_CM v2.0
Laboratory result Common Measures (CM) use specific types of quantitative and qualitative measurements from blood and other body specimens. These standardized measures are defined in the same way across all PCORnet networks.

PCORNET_TRIAL v3.0
Patients who are enrolled in PCORnet clinical trials.

PRESCRIBING v3.0
Provider orders for medication dispensing and/or administration.

PRO_CM v2.0
Patient-Reported Outcome (PRO) Common Measures (CM) are standardized measures that are defined in the same way across all PCORnet networks. Each measure is recorded at the individual item level: an individual question/statement, paired with its standardized response options.

PROCEDURES v1.0
Procedure codes indicate the discreet medical interventions and diagnostic testing, such as surgical procedures, administered within healthcare delivery.

VITAL v1.0
Vital signs (such as height, weight, and blood pressure) directly measure an individual's current state of attributes.

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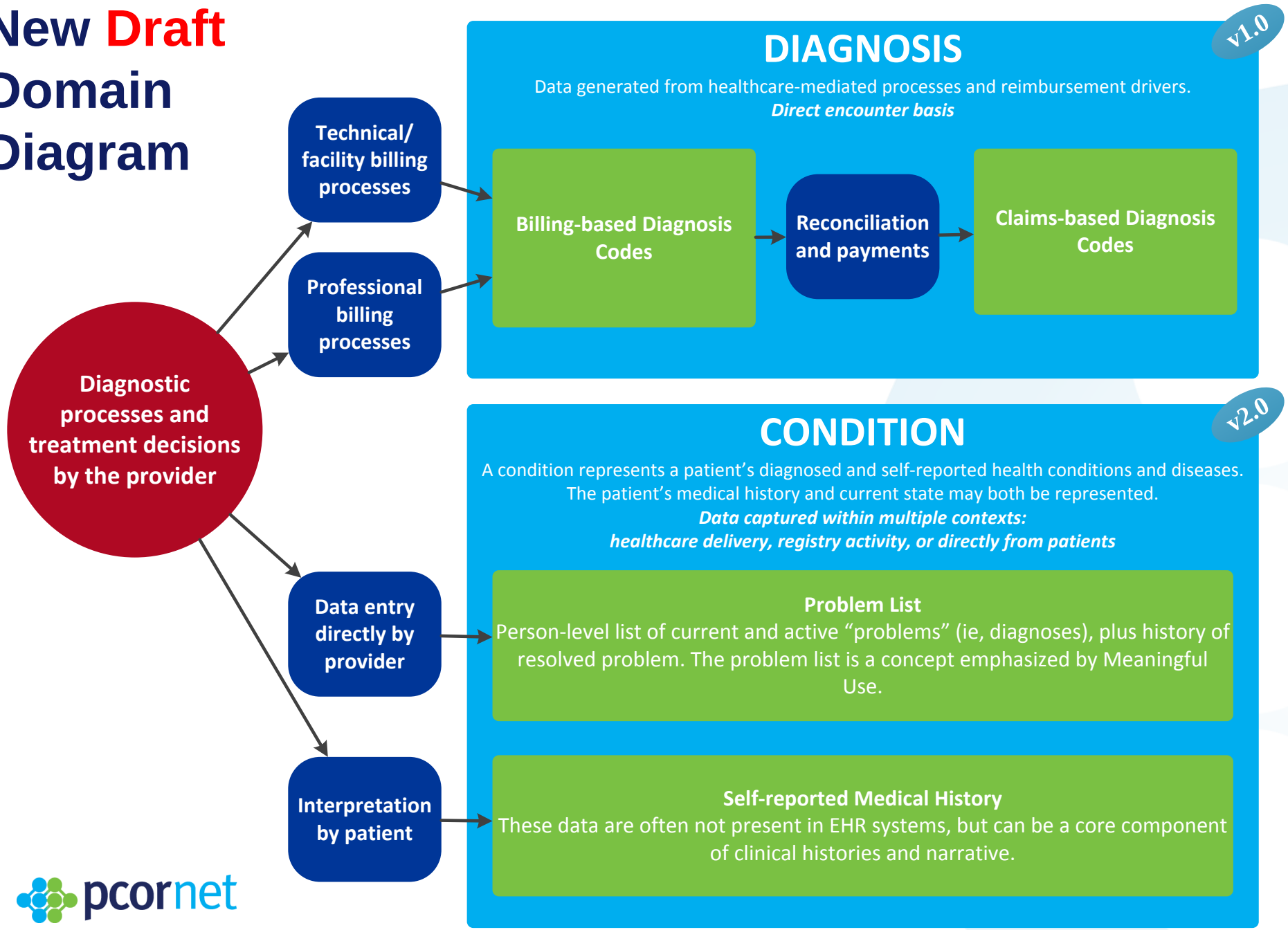
New Draft Domain Diagram



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Theme: Phenotypes

- Process of developing computable algorithms to recognize/define disease states and conditions

Study-created code (eg, "BAR_OBESITY_1_0")

New value item: AG = Algorithmic

New value item: PC = PCORnet-defined cohort algorithm

CONDITION Table Specification

Field Name	*Data Type*	*Predefined Value Sets and Descriptive Text for Categorical Fields*	*Definition / Comments*
CONDITION	TEXT(18)	.	Condition code. Leading zeroes and different levels of decimal precision are permissible in this field. Please populate the exact textual value of this diagnosis code, but remove source-specific suffixes and prefixes. Other codes should be listed as recorded in the source data.
CONDITION_TYPE	TEXT(2)	09=ICD-9-CM 10=ICD-10-CM 11=ICD-11-CM SM=SNOMED CT HP=Human Phenotype Ontology NI=No information UN=Unknown OT=Other	Condition code type. Please note: The "Other" category is meant to identify internal use ontologies and codes.
CONDITION_SOURCE	TEXT(2)	PR=Patient-reported medical history HC=Healthcare problem list RG=Registry cohort NI=No information UN=Unknown OT=Other	Please note: The "Patient-reported" category can include reporting by a proxy, such as patient's family or guardian. Guidance: "Registry cohort" generally refers to cohorts of patients flagged with a certain set of characteristics for management within a health system. "Patient-reported" can include self-reported medical history and/or current medical conditions, not captured via healthcare problem lists or registry cohorts.

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Slide from CDM v3.0 Development Stakeholder Meeting on April 29, 2015

CONDITION	RDBMS Text(18)	SAS Char(18)	.	Condition code. Leading zeroes and different levels of decimal precision are permissible in this field. Please populate the exact textual value of this diagnosis code, but remove source-specific suffixes and prefixes. Other codes should be listed as recorded in the source data.	PCORnet (modeled upon DIAGNOSIS table)
CONDITION_TYPE	RDBMS Text(2)	SAS Char(2)	09=ICD-9-CM 10=ICD-10-CM 11=ICD-11-CM SM=SNOMED CT HP=Human Phenotype Ontology AG=Algorithmic NI=No information UN=Unknown OT=Other	Condition code type. Please note: The "Other" category is meant to identify internal use ontologies and codes. v3.0 amendment: The new categorical value of AG has been added.	PCORnet (modeled upon DIAGNOSIS table)
CONDITION_SOURCE	RDBMS Text(2)	SAS Char(2)	PR=Patient-reported medical history HC=Healthcare problem list RG=Registry cohort PC=PCORnet-defined condition algorithm NI=No information UN=Unknown OT=Other	Please note: The "Patient-reported" category can include reporting by a proxy, such as patient's family or guardian. Guidance: "Registry cohort" generally refers to cohorts of patients flagged with a certain set of characteristics for management within a health system. "Patient-reported" can include self-reported medical history and/or current medical conditions, not captured via healthcare problem lists or registry cohorts. v3.0 amendment: The new categorical value of PC has been added.	PCORnet (modeled upon VITAL table)

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CONDITION table, CDM v3.0 release, page 58

http://www.pcornet.org/pcornet-common-data-model/

Topic 2

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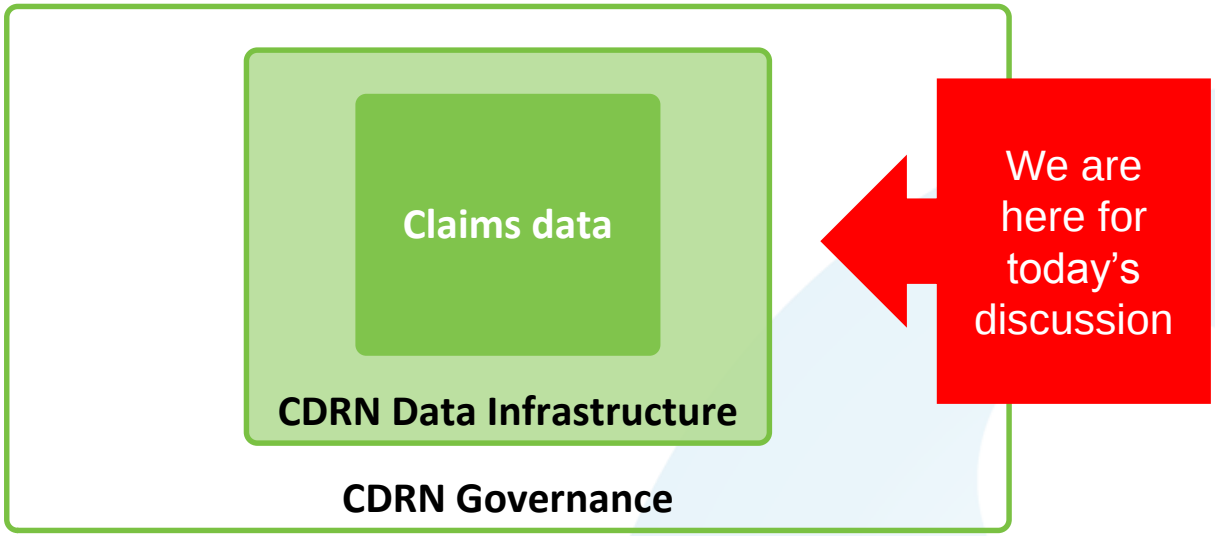
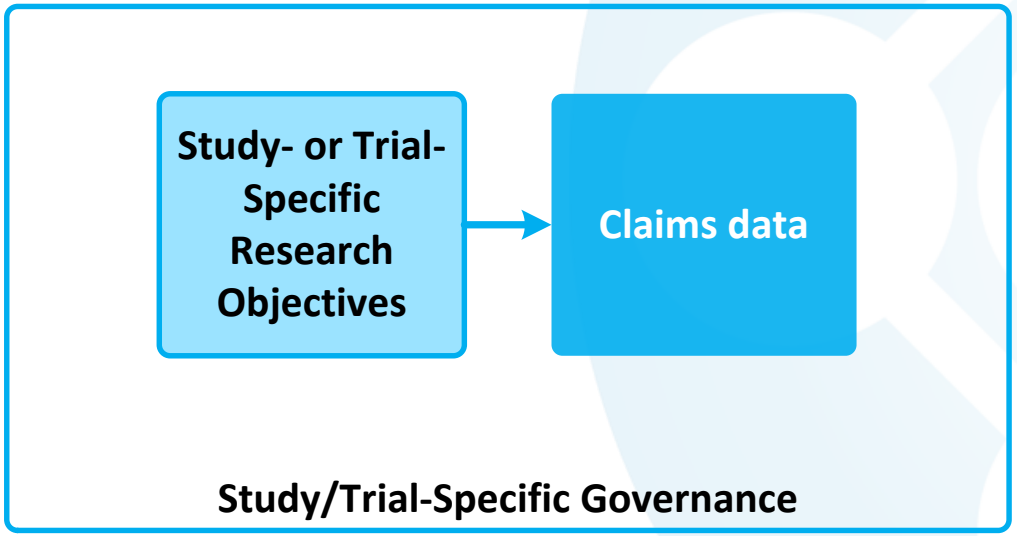
Scenario 1:
CDRN acquires, manages, and governs claims data within their own data infrastructure.

Multiple configurations and architectures will be possible within different networks.



Scenario 2:
PCORnet-sponsored trial or study manages analysis of claims data for specific research purposes.

Examples of external source may include Medicare, private health plans, Sentinel partners, and others.



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