

# Quality Data Model (QDM) User Group Meeting | Minutes

Meeting date | 10/16/2019 2:30 PM ET | Meeting location | Webinar link:  
<https://esacinc2.webex.com/esacinc2/j.php?MTID=mbe337acc5ac0aac5461266116ed257e3>

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Announcements	Jen Seeman (ESAC)	<ul style="list-style-type: none"> <li>- <b>Cooking with CQL Webinar was held on October 24<sup>th</sup> at 4:00 PM ET.</b> These sessions are generally held on the third Thursday monthly. Upcoming events can be found by going to the <a href="#">eCQI Resource Center events page</a>.               <ul style="list-style-type: none"> <li>o Please submit CQL-related questions to <a href="mailto:cql-esac@esacinc.com">cql-esac@esacinc.com</a>.</li> </ul> </li> <li>- The next QDM User Group (UG) meeting is November 13<sup>th</sup> (one week early).</li> </ul>
30 Minutes	Laboratory Test, Performed Result dateTime <a href="#">QDM-240</a>	Floyd Eisenberg (ESAC)	<p><b>Overview:</b>            Jira ticket <a href="#">QDM-240</a> requested clarification of the description for the QDM attribute Laboratory Test, Performed <i>result dateTime</i>. The question is specific to eCQM CMS122 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt; 9%); however, it is significant for any use of <i>result dateTime</i>. Current QDM definition for <i>result dateTime</i>: "The time the result report is generated and saved in the database"</p> <p>The current description actually suggests two times:</p> <ul style="list-style-type: none"> <li>▪ When the result report was generated by those performing the diagnostic study or laboratory test</li> <li>▪ When the result report was saved in the EHR database for viewing by clinicians</li> </ul> <p><b>Recap:</b>            Current timing options for Laboratory Test, Performed and QDM to QI-Core mappings:</p> <ul style="list-style-type: none"> <li>▪ Relevant dateTime maps to the <i>physiologic time</i> as defined in CDA or, the <a href="#">Observation.effective [x]</a> in QI-Core.<sup>1</sup> Definition: "The time or time-period the observed value is asserted as being true. For biological subjects - e.g. human patients - this is usually called the "physiologically relevant time". This is usually either the time of the procedure or of specimen collection, but very often the source of the date/time is not known, only the</li> </ul>

<sup>1</sup> Note: the link provided is to the QI-Core R4 ballot version.

Time	Item	Presenter	Discussion/Options/Decisions
			<p>date/time itself.”</p> <ul style="list-style-type: none"> <li>▪ Result dateTime which maps to QI-Core <u>Observation.issued</u>.<sup>2</sup> Definition: "The date and time this version of the observation was made available to providers, typically after the results have been reviewed and verified."</li> </ul> <p><b>Discussion:</b> Since Result dateTime = <u>Observation.issued</u>, should we publish a QDM Known Issue clarifying that <i>result dateTime</i> indicates when the result report was generated by those performing the diagnostic study or laboratory test?</p> <ul style="list-style-type: none"> <li>• Feedback from an implementation site (Joe Kunisch, Memorial Hermann) and three vendors (Howard Bregman, Epic; Isbelia Briceno, Cerner; and Anne Coultas, McKesson) notes that most systems utilize two times; collection time of the sample and result time that most closely aligns with ‘issued’ or made available.</li> <li>• Peter Muir noted that there are cases where the data goes through a health information exchange (HIE) which could delay results being available; still other cases where clinicians request results should be held until all final results from a panel are finalized. The resulting discussion indicated that such differences in availability result from local implementation issues that are beyond the purview of eCQM developers.</li> </ul> <p><b>Resolution/Next Steps:</b></p> <ul style="list-style-type: none"> <li>• The QDM User Group agreed to proceed with a QDM Known Issue to more accurately describe <i>result dateTime</i>.</li> <li>• Yanyan Hu (The Joint Commission) agreed to provide an example for use of <i>result dateTime</i> from an existing Eligible Hospital (EH) measure. She will also suggest some language for inclusion in a proposed QDM Known Issue.</li> <li>• ESAC will review the resulting QDM Known Issue with the eCQM Governance Group and the eCQM Working Group before finalization.</li> </ul>

<sup>2</sup> Note: the link provided is to the QI-Core R4 ballot version.

Time	Item	Presenter	Discussion/Options/Decisions
15 Minutes	Recap – Procedure <i>priority</i> attribute <a href="#">QDM-239</a>	Floyd Eisenberg (ESAC)	<p><b>Overview:</b>  This issue is a recap from the August 2019 discussion with an update regarding FHIR QI-Core representation. The QDM User Group added <i>priority</i> as a QDM attribute in version 5.5 to allow reference to elective encounters, orders and procedures. During the effort to map QDM to QI-Core the encounter and order priority mapped directly, but QI-Core (and base FHIR does not have a concept of a procedure.priority. Further details about the need for <i>elective</i> procedures can be found in a closed Jira ticket <a href="#">QDM-212</a>.</p> <ul style="list-style-type: none"> <li>▪ The use case initially presented: <ul style="list-style-type: none"> <li>– A surgeon’s office calls to schedule a procedure (elective or urgent)</li> <li>– Scheduling identifies a date and schedules admission corresponding to the procedure date identified</li> <li>– The patient performs pre-admission testing, registration and arrives for admission</li> <li>– The physician may order the procedure as an admission order, but very likely does not write a specific procedure order</li> </ul> </li> <li>▪ FHIR has an Appointment resource with an Appointment.priority attribute. However, Appointment.priority is represented by an integer, not a code; thus, it does not represent the concept of <i>elective</i>. Also, the Appointment.priority attribute includes a comment, “Seeking implementer feedback on this property and how interpretable it is.”</li> <li>▪ The FHIR Schedule resource is defined as “a container for slots of time that may be available for booking appointments.” Therefore, Appointment is not necessarily appropriate for this “elective” use case.</li> <li>▪ Since physicians may not order the procedure, ServiceRequest may not work.</li> </ul> <p>Current FHIR Mappings:</p> <ul style="list-style-type: none"> <li>▪ ServiceRequest.priority – SHALL use values "routine", "urgent", "asap", "stat"  <a href="http://hl7.org/fhir/us/qicore/2019Sep/StructureDefinition-qicore-servicerequest-definitions.html#ServiceRequest.priority">http://hl7.org/fhir/us/qicore/2019Sep/StructureDefinition-qicore-servicerequest-definitions.html#ServiceRequest.priority</a> <ul style="list-style-type: none"> <li>– Adding a new term to the priority value set requires update from the workgroup responsible for the FHIR resource or an extension in QI-Core</li> </ul> </li> <li>▪ The Encounter resource element "<a href="#">Encounter.priority</a>" SHOULD include values like "elective", "emergency", "routine", "urgent", etc.</li> </ul> <p>ESAC asked the User Group to consider options to address procedure priority.  Some considerations:</p> <ul style="list-style-type: none"> <li>• Does ServiceRequest.priority = "routine" mean the same thing as "elective"?</li> <li>• Can Procedure referencing a ServiceRequest meet the requirement? --- QI-Core</li> </ul>

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			<p>Procedure includes a <u>Procedure.basedOn</u> option that allows reference to the order (ServiceRequest) that initiated the procedure. However, QDM does not include any <i>relatedTo</i> option for Procedure, Performed. Further, some procedures do not include an order in the workflow.</p> <ul style="list-style-type: none"> <li>• Can Encounter with <u>Encounter.priority</u> suffice?</li> </ul> <p>Recap from August 2019 – Question for Implementers about availability of information about elective procedures: Vendor responses to date:</p> <ul style="list-style-type: none"> <li>• Epic: there is a value attached to the surgical case record that indicates the elective status of the procedure, but it is not Boolean - i.e., it includes elective and several levels of non-elective (e.g., "needs to be done within the hour" to "needs to be done within 12 hours").</li> <li>• Allscripts: there doesn't seem to be a standard for documenting procedure priority.</li> </ul> <p><b>Discussion:</b> Yanyan Hu (The Joint Commission) reviewed the use case to explain the reason for needing to determine an elective procedure from any other procedure performed during an admission. One option might be to identify a principal procedure during an elective encounter. However, principal procedure. Anne Coultas (McKesson) noted that a principal procedure definition is different that principal diagnosis: Reference QDM-226: The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication. <a href="https://manual.jointcommission.org/releases/TJC2015B/DataElem0685.html">https://manual.jointcommission.org/releases/TJC2015B/DataElem0685.html</a> Hence, a principal procedure combined with an elective encounter (Encounter.priority = elective) may not be sufficient. Another option is to use Procedure.basedOn a ServiceRequest with ServiceRequest.priority = elective (may require a QI-Core extension since elective is not an option in the existing value set). However, in the absence of a QDM Procedure, Performed attribute <i>relatedTo</i>, there is no definitive QDM option except Procedure, Performed <i>priority</i>. ESAC asked the User Group if a QDM Known Issue might help to address how implementers might address the Procedure, Performed <i>priority</i> attribute. Yanyan Hu (The Joint Commission) suggested we wait until The Joint Commission receives responses from the current eCQM change review process (CRP) in which measure developers ask for implementer feedback about feasibility of measure components and changes.</p>

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			<p>Rob McClure (MD Partners) asked whether Encounter, Performed <i>priority</i> might be sufficient; i.e., how often might an urgent procedure occur at the beginning of an elective encounter. Mia Nievera (The Joint Commission) noted that some planned procedures become more urgent such that the encounter is moved up but keeps the <i>elective</i> priority. In such cases the expected pre-admission testing is not completed in advance. The discussion further questioned the value of capturing all detail to avoid including such situations in the denominator, i.e., perhaps applying the 80-20 rule might include a few patients in the denominator with planned elective procedures that became more urgent. However, is the amount of effort to exclude them potentially adding implementer burden?</p> <p><b><u>Resolution/Next Steps:</u></b> The User Group agreed to await feedback from the CRP process as suggested by The Joint Commission attendees before considering specific advice or a QDM Known Issue.</p>
15 Minutes	Negation Rationale timing <a href="#">QDM-241</a>	Floyd Eisenberg (ESAC)	<p><b><u>Overview:</u></b> The <a href="#">QDM-241</a> Jira ticket raised a question about how often a practitioner needs to document negation rationale; i.e., document the reason at every visit, or can a reason documented on a prior visit be sufficient? Considerations:</p> <ul style="list-style-type: none"> <li>▪ Some EHRs have functionality so that providers may document the length of time an intervention should be deferred based on medical reasons or patient preferences.</li> <li>▪ For example, if a patient declines a flu shot at the beginning of the flu season but says they will think about it, the provider can defer for two months (for the codified reason of “patient refused”) so that when the patient returns for follow-up, the issue can be raised again. If the patient says they don’t want one this season, the length of time can be set to 11 months so that when the patient returns the next flu season, it can be readdressed. If the patient says they are a life-long Christian Scientist and have never received a flu shot and will never accept one, the immunization can be permanently deferred (for the codified reason of patient refused for religious reasons) and the provider need never ask again.</li> <li>▪ Implementers would like to use the provider designated length of time in reporting logic so that the deferral is valid during the specified timeframe (e.g. 2 months, 11 months, forever). In the final example of the patient who refused for religious reasons, this prevents the provider from harassing the patient each year and completing unnecessary documentation each year.</li> <li>▪ Example: CMS 147 Preventive Care and Screening: Influenza Immunization Patient Declined Influenza Vaccination ["Communication: From Patient To Provider": "Influenza Vaccination Declined"] CommunicateFluVaccinationDeclined</li> </ul>

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			<p>where CommunicateFluVaccinationDeclined.authorDatetime during "Influenza Season Including August and September of the Prior Year"</p> <p>Consider how to address a deferral "validity period"</p> <p>Some FHIR Resources indicate an expected date or period when a request should occur (ServiceRequest.occurrenceDateTime or ServiceRequest.occurrencePeriod).</p> <p>Except for MedicationRequest which includes a .validityPeriod, QI-Core/FHIR does not have a clear method to address a "validity period" for negation.</p> <p>Should QDM include a Known Issue to address this issue?</p> <p><b>Discussion:</b></p> <p>The QDM User Group implementers and vendors suggested that short-term deferrals may not be documented at all, such as the decision to wait and ask again about influenza vaccine. Many EHRs have the ability to indicate length of time to apply a deferral. In the specific eCQM referenced, the CQL expression allows refusal by a patient documented any time during the "Influenza Season Including August and September of the Prior Year" such that the documentation does not need to occur at every visit. The specific measure request was referred back to the measure developer for a response.</p> <p>The QDM User Group did not see a need for a QDM Known Issue.</p> <p><b>Resolution/Next Steps:</b></p> <p>No follow up required – asked and answered.</p>
15 Minutes	Medication, Active <a href="#">QDM-242</a>	Floyd Eisenberg (ESAC)	<p><b>Overview:</b></p> <p><b>QDM Medication, Active <a href="#">QDM-242</a></b></p> <p>The QDM Defines the Relevant Period StopTime for Medication, Active as: StopTime = when the medication is discontinued (generally, the time discontinuation is recorded on the medication list)</p> <p>This definition seems to require that a provider specifically discontinue a medication from the medication list.</p> <ul style="list-style-type: none"> <li>▪ Does this include lapsed prescriptions?</li> <li>Or</li> <li>▪ Only prescriptions that were manually discontinued?</li> </ul> <p>QDM does not specify how to derive the information about stopped medications. If the EHR can identify a prescription has lapsed that should meet the intent of QDM. However, a lapsed prescription might indicate the patient is no longer taking the medication but the physician's intent is not to discontinue it.</p>

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			<p>Does QDM require clarification for implementers?</p> <ul style="list-style-type: none"> <li>▪ Should the definition of StopTime be something like "When the medication is discontinued or there is evidence the patient is no longer taking the medication."</li> <li>▪ "Discontinued," therefore, could be an active or passive concept.</li> <li>▪ For most medication lists (the intent of Medication, Active), removal from the list is an active process performed by a clinician.</li> <li>▪ FHIR MedicationRequest.status options "active" "completed" "cancelled" and "stopped". <ul style="list-style-type: none"> <li>– Is that alone sufficient (i.e., without evidence of what has been dispensed and when)?</li> </ul> </li> </ul> <p><b>Discussion:</b> The User Group discussed the issue indicating several scenarios:</p> <ul style="list-style-type: none"> <li>• The medication may have lapsed based on dispensed medications but the patient may be taking it at a reduced frequency; thus the patient remains on the medication even though it has lapsed.</li> <li>• Some EHRs automatically removed medications from a medication list based on a locally determined time after it has lapsed.</li> <li>• Without clearly matching orders from dispensing events, the actual number of remaining doses cannot be determined.</li> <li>• The only way to address this issue is to indicate "When the medication is no longer active"</li> </ul> <p><b>Resolution/Next Steps:</b> The QDM User Group agreed to create a Known Issue to indicate the definition is "When the medication is no longer active." ESAC will prepare a QDM Known Issue and review it with the eCQM Governance Group and the eCQM Working Group.</p>
30 Minutes	Medication <i>dose</i> definition question	Floyd Eisenberg (ESAC)	<p><b>Overview:</b> Current definition:</p> <ul style="list-style-type: none"> <li>▪ Details of how medication is taken or is to be taken, i.e., the quantity (mg, cc, tablets) to be taken at a single administration.</li> </ul> <p>Consider the need to add a word for clarity:</p> <ul style="list-style-type: none"> <li>– Details of how <b>much</b> medication is taken or is to be taken, i.e., the quantity (mg, cc, tablets) to be taken at a single administration. <ul style="list-style-type: none"> <li>– Is this change really needed in the document?</li> </ul> </li> </ul>

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			<p style="text-align: center;">– Should a Known Issue exist to clarify?</p> <p><b>Discussion:</b> The QDM User Group agreed that adding the word “much” to the description would add value in the next version of QDM. The group agreed that the existing language was sufficiently clear such that a Known Issue is not required.</p> <p><b>Resolution/Next Steps:</b> No action at this time. However, in the next QDM version add the additional word to the statement to read, “Details of how <b>much</b> medication is taken or is to be taken, i.e., the quantity (mg, cc, tablets) to be taken at a single administration.</p>
30 Minutes	QDM to QI-Core mapping– Device, Applied	Floyd Eisenberg (ESAC)	<p><b>Overview:</b> <b>QDM Device, Applied</b> Current use references the procedure to “apply” the device (i.e., to use for the patient, to use on the patient’s body, or to implant in the patient’s body).</p> <ul style="list-style-type: none"> <li>▪ The FHIR Resource DeviceUseStatement (<a href="http://hl7.org/fhir/deviceusestatement.html">http://hl7.org/fhir/deviceusestatement.html</a>) is defined as "A record of a device being used by a patient where the record is the result of a report from the patient or another clinician." It is an event resource from a FHIR workflow perspective.</li> <li>▪ Feedback at the Atlanta September WGM suggests that the QDM concept of Device, Applied best fits with the QI-Core Procedure Resource.</li> <li>▪ To reference a specific device type managed by the Procedure resource, use <u>Procedure.focalDevice.manipulated</u> with the <u>device.type</u></li> </ul> <p>Further, DeviceRequest is defined as “the request for the use of a device by a patient. The device may be any pertinent device specified in the Device resource. Examples of devices that may be requested include wheelchair, hearing aids, or an insulin pump. The request may lead to the dispensing of the device to the patient or for use by the patient.”</p> <p><b>Discussion:</b> Based on the definition of DeviceRequest in QI-Core and FHIR, the User Group agreed that QDM Device, Order is most consistent with a procedure order; hence ServiceRequest is the most appropriate mapping in FHIR. The details regarding how to use QI-Core procedure to define a Device, Applied will be determined in HL7 Clinical Quality Information (CQI) Workgroup calls. The Joint Commission will work with the</p>

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			<p>CQI group to provide examples using the Procedure resource.</p> <p><b>Resolution/Next Steps:</b> The QDM to QI-Core mapping in FHIR will map Device, Applied to Procedure and Device, Order / Device, Recommended to ServiceRequest.</p>																																				
30 Minutes	QDM to QI-Core mapping– QDM Medication, Active	Floyd Eisenberg (ESAC)	<p><b>Overview:</b> <b>QDM Medication, Active</b> Previous mapping used MedicationStatement, however, the US Core Update recommends MedicationRequest:</p> <table border="1"> <thead> <tr> <th>QDM Context</th> <th>QI-Core R4</th> <th>Comments</th> </tr> </thead> <tbody> <tr> <td>Medication, Active</td> <td>MedicationRequest</td> <td></td> </tr> <tr> <td></td> <td><a href="#">MedicationRequest.status</a></td> <td>Constrain to "active"</td> </tr> <tr> <td></td> <td><a href="#">MedicationRequest.intent</a></td> <td>Constrain to "order"</td> </tr> <tr> <td></td> <td><a href="#">MedicationRequest.category</a></td> <td>inpatient, outpatient, community, patient-specified (used to specify if the medication active list is for inpatient, outpatient service, community (ambulatory) settings and most useful for identifying a discharge medication list using the community reference)</td> </tr> <tr> <td>code</td> <td><a href="#">MedicationRequest.medication[x]</a></td> <td></td> </tr> <tr> <td>id</td> <td><a href="#">MedicationRequest.id</a></td> <td></td> </tr> <tr> <td>Dosage</td> <td><a href="#">MedicationRequest.dosageInstruction.doseAndRate.dose[x]</a></td> <td>Amount of medication per dose.</td> </tr> <tr> <td>frequency</td> <td><a href="#">MedicationRequest.dosageInstruction.timing</a></td> <td></td> </tr> <tr> <td>route</td> <td><a href="#">MedicationRequest.dosageInstruction.route</a></td> <td></td> </tr> <tr> <td></td> <td><a href="#">MedicationRequest.reasonCode</a></td> <td></td> </tr> <tr> <td>relevant dateTime</td> <td>NA</td> <td></td> </tr> </tbody> </table>	QDM Context	QI-Core R4	Comments	Medication, Active	MedicationRequest			<a href="#">MedicationRequest.status</a>	Constrain to "active"		<a href="#">MedicationRequest.intent</a>	Constrain to "order"		<a href="#">MedicationRequest.category</a>	inpatient, outpatient, community, patient-specified (used to specify if the medication active list is for inpatient, outpatient service, community (ambulatory) settings and most useful for identifying a discharge medication list using the community reference)	code	<a href="#">MedicationRequest.medication[x]</a>		id	<a href="#">MedicationRequest.id</a>		Dosage	<a href="#">MedicationRequest.dosageInstruction.doseAndRate.dose[x]</a>	Amount of medication per dose.	frequency	<a href="#">MedicationRequest.dosageInstruction.timing</a>		route	<a href="#">MedicationRequest.dosageInstruction.route</a>			<a href="#">MedicationRequest.reasonCode</a>		relevant dateTime	NA	
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relevant period	<a href="#">MedicationRequest.dispenseRequest.validityPeriod</a>											
	<a href="#">MedicationRequest.authoredOn</a>	Missing										
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5 Minutes	General Discussion	Floyd Eisenberg (ESAC)	Attendees had no further questions or discussion topics.									
5 Minutes	Next Meeting	Jen Seeman (ESAC)	<p><b>Agenda items for next QDM user group meeting</b></p> <ul style="list-style-type: none"> <li>– Contact us at <a href="mailto:qdm@esacinc.com">qdm@esacinc.com</a></li> <li>– Or start a discussion: <a href="mailto:qdm-user-group-list@esacinc.com">qdm-user-group-list@esacinc.com</a></li> </ul> <p><i>If you attend the QDM User Group meetings but do not receive communications or have access to the QDM User Group List, please send an email to <a href="mailto:QDM@esacinc.com">QDM@esacinc.com</a> so you may be added to the distribution list.</i></p> <p><b>Next user group meeting</b></p> <ul style="list-style-type: none"> <li>– Regularly Scheduled Meeting – The next monthly meeting will occur on November 13, 2019 from 2:30 to 4:30 PM ET.</li> </ul>									

## Invitees/Attendees:

	Name	Organization
	Abrar Salam	The Joint Commission
	Alex Borenstein	Greenway Health
	Alex Lui	Epic
	Andy Kubilius	The Joint Commission
X	Angela Flanagan	Lantana
	Ann-Marie Dunn	Unknown
	Ann Philips	NCQA
	Anna Bentler	The Joint Commission
X	Anne Coultas	McKesson
	Anne Smith	NCQA
	Amira Elhagmusa	Battelle
	Balu Balasubramanyam	MITRE
	Ben Hamlin	NCQA
	Benjamin Bussey	Unknown
	Beth Bostrom	AMA
	Brian Blaufeux	Northern Westchester Hospital
X	Brook Villarreal	Unknown
	Bryn Rhodes	ESAC
	Carolyn Anderson	Primary care practice
	Chana West	ESAC
	Chris Moesel	MITRE
	Cindy Lamb	Telligen
X	Claudia Hall	Mathematica
	Corrie Dowell	BSW Health
	Dalana Ostile	Providence Health Systems
	Dawn Lane	Covenant Health
	Dave Wade	Apprio
X	David Clayman	Allscripts
	Debbie Hall	University of Maryland
	Deidre Sacra	McKesson
	Doug Goldstein	Epic
X	Floyd Eisenberg	ESAC
	Gary Rezik	QIP
	Ganesh Shanmugam	Glenwood Systems
X	Howard Bregman	Epic
	Hyok-Hee Yoo	Medisolv
X	Isbelia Briceno	Cerner
	James Bradley	MITRE
	Jamie Lehner	PCPI
	Jana Malinowski	Cerner
	Jean Fajen	Telligen
	Jenna Williams-Bader	NCQA
	Jill Shuemaker	VCU Health
	John Carroll	The Joint Commission
	John Lujan	Kaiser Permanente
	Jessica Smalls	Caradigm
	Joseph Kunisch	Memorial Hermann
	Johanna Ward	Mathematica
	Jorge Belmonte	PCPI

	Name	Organization
	L Dejesus	Informedika
X	Lisa Anderson	The Joint Commission
	Lizzie Charboneau	MITRE
X	Lynn Perrine	Lantana
	Marc Hadley	MITRE
X	Marc Hallez	The Joint Commission
	Marc Overhage	Cerner
	Margaret Dobson	Zepf Center
	Matt Hardman	Unknown
X	Marilyn Parenzan	The Joint Commission
	Martha Radford	NYU
	Melissa Van Fleet	Alliance Health Oklahoma
X	Mia Nievera	The Joint Commission
	Michael Mainridge	Unknown
	Michelle Dardis	Mathematica
	Michelle Hinterberg	MediSolv
	Mike Shoemaker	Telligen
	Mukesh Allu	Epic
	Nathan R	Unknown
	Neelam Zafar	The Joint Commission
	Norm Sirois	Unknown
	Pamela Mahan-Rudolph	Memorial Hermann
X	Paul Denning	MITRE
X	Peter Muir	ESAC
	Rachel Buchanan	Oregon Urology
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	Ruth Gatiba	Battelle
	Ryan Clark	NCQA
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	Jay Frails	Meditech
X	Katie Magoulick	CMS
	Kendra Hanley	HSAG
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	Latasha Archer	NCQA
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