Quality Data Model (QDM) User Group Meeting | Minutes

Meeting date | *10/21/2020 2:30 PM ET* | Meeting location|Webinar https://global.gotomeeting.com/join/980942653

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Announcements	Jen Seeman (ESAC)	• A Cooking with CQL session was held on October 29, 2020. • Next QDM User Group Meeting November 18, 2020
20 Minutes	Defining Primary versus Principal Diagnosis	Floyd Eisenberg (ESAC)	**Overview:** **"Encounter, Performed" *diagnosis* Use Case** The September 2020 HL7 Plenary and Working Group meeting addressed an issue about defining a *primary diagnosis* which is distinct from *principal diagnosis*. The use case considered is that a patient should see the same diagnosis on the clinical visit summary as the Explanation of Benefits (EOB – claim) to avoid confusion or potential concerns about fraudulent claims. The concept addresses "What the clinician thinks is the most important diagnosis out of a set of encounter diagnoses." • Currently, the CARIN Alliance defines principal diagnosis "The circumstances of inpatient admission always govern the selection of principal diagnosis.[1] The principal diagnosis is defined in the Uniform Hospital Discharge Set (UHDDS) as 'that condition established after study to be chiefly responsible for occasioning the admission to the hospital for care.' The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985 Federal Register (Vol. 50, No. 147), pp 31038-40. Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). The UHDDS definitions also apply to hospice services (all levels of care)." ICD-10 diagnosis code are maintained by the National Centers for Health Statistics out of CDC. The guidelines are available at: https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf.

[1] Full presentation from CARIN available at: CARIN Slide Deck from HL7 WGM 25 September 2020 Financial Management Discussion

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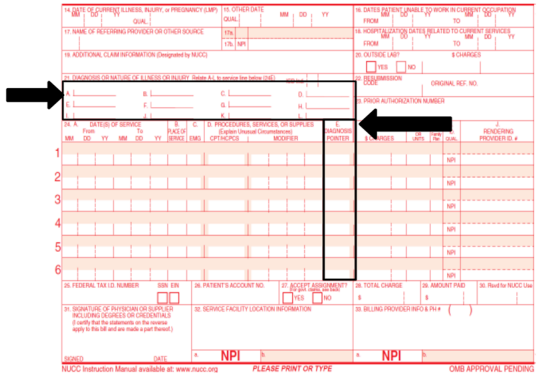
			• CDA® R2 IG: National Health Care Surveys (NHCS): "Primary diagnosis: Primary diagnosis is an important organizing or grouping variable for patient encounters across inpatient, outpatient, and emergency settings and is used to record the encounter diagnosis of central focus and/or most important diagnosis among a set of encounter related diagnoses." Source: HL7 CDA® R2 Implementation Guide: National Health Care Surveys (NHCS), R1 STU Release 3 - US Realm, Volume 2 - Templates and Supporting Material, February 2020. **Note:** The STU 3 of the NHCS Implementation Guide (IG) includes the language indicated and uses a LOINC code for Primary diagnosis (18630-4). However, the current version of the NHCS IG in use is STU 1.2 referencing primary diagnosis with the LOINC code 52534-5, principal diagnosis. • The term *primary* does not seem to be a requirement for claim submission. The Medicare Claims Processing Manual (rev 10211 7-10-20) Chapter 23 describes a professional claim as the first diagnosis as a line item. "Outpatient Claims Diagnosis Reporting: For outpatient claims, provider report the full diagnosis codes for up to 24 other diagnoses that coexisted in addition to the diagnosis reported as the principal diagnosis." Thus, for professional (ambulatory) claims, the term principal diagnosis is still used. A professional claim (Figure 1. CMS-1500 Claim Form Example) allows listing of up to 12 diagnosis codes on line 21, each represented by a letter. Each service listed in section 24 allows pointers in column E to up to 3 diagnosis pointers to the diagnoses listed in line 21 (I.e., entry of letters representing the diagnoses). The first letter listed in column E for each service is the principal, or primary diagnosis for that service/procedure. The remaining diagnosis pointers indicate declining level of importance to the service line.

CARIN IG for Blue Button®

Professional (CMS-1500) | Coding Diagnosis Codes

Reference the CMS-1500 Instructions on the National Uniform Claim Committee (NUCC)



While up to 12 diagnosis codes can be included on a single claim form, only four of those diagnosis codes can map to a specific procedure code.

Diagnosis code pointers are used to indicate the appropriate order of importance in relation to the service being performed. The first pointer designates the primary diagnosis for the service line. Remaining diagnosis pointers indicate declining level of importance to the service line.

Figure 1. CMS-1500 Claim Form Example

Summary from HL7 sessions:

- Definition of *primary* diagnosis in the clinical community seems to be inconsistent
- Documentation for claim submission will follow rules for claims
- Claim designation of diagnosis may not correlate with the patient's perception of primary reason for visit

Discussion:

Joe Kunisch (Memorial Hermann) - Agreed with maintaining the current practice. We have *principal diagnosis* and everything else is secondary. Howard Bregman (Epic) - Agreed with the proposal to continue the current practice.

Ping Jiang (TJC) asked if implementers should continue to use diagnosis.use=billing. ESAC suggested there is no change. The FHIR Encounter.diagnosis.use element uses a value set containing specific roles: admission, discharge, chief complaint, comorbidity, pre-op diagnosis, post-op diagnosis and billing. Admission is not always the principal diagnosis. ESAC suggested the role of billing is still necessary. There is no *principal* concept in the diagnosis role value set.

Next Steps for Consideration:

- Maintain current practice of claim diagnosis with rank = 1 for principal diagnosis
- Avoid use of primary diagnosis and defer to claims

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			• No change in QDM or QI-Core mapping - continue to map consistent with the Encounter resource, not the Claim resource **Related Issues Of note:** • The Patient Administration Work Group (HL7) is considering a request from Patient Care Work Group to separate Encounter.diagnosis into Encounter.diagnosis and Encounter.procedure. Currently they are both combined under the definition of Encounter.diagnosis. **Resolution/Next Steps:** No attendees suggested any change is needed to the current practice of billing *diagnosis* with *rank* = 1 for *principal diagnosis*.
20 Minutes	Symptom - QDM-260	Floyd Eisenberg (ESAC)	**Overview:** From NCQA: The current QI Core mapping suggests using FHIR.Observation with category constrained to 'symptom', found here. The documentation does make it clear that this is a category code that would need to be added by the measure developer, as it is not included in ObservationCategoryCodes currently. We have concerns that, since this would be a user-defined category, we may run into mapping and data issues with end users. Use cases: 1. **Symptom is used as one method of identifying a depression-related encounter. This is used in conjunction with three other unioned Encounter/Diagnosis combinations.** ((["Encounter, Performed": "Depression Case Management Encounter"]) CaseManagementEncounter with (["Symptom": "Symptoms of depression (finding)"]) DepressionSymptoms such that DepressionSymptoms.prevalencePeriod starts same day as start of CaseManagementEncounter.relevantPeriod) 2. **Symptom is used as a method of identifying Frailty, as part of a larger definition:** or exists (["Symptom": "Frailty Symptom"] FrailtySymptom where FrailtySymptom.prevalencePeriod overlaps "Measurement Period")

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			Example 1 above uses a Direct Reference Code using 394924000 (SNOMEDCT). **Example 2** references a value set consisting of mainly SNOMEDCT codes, along with a handful of ICD10CM codes. The QDM mapping to QI-Core is based on the FHIR R4.0.1 guidance in Boundaries and Relationships: *This resource is not typically used to record information about subjective and objective information that might lead to the recording of a Condition resource. Such signs and symptoms are typically captured using the Observation resource; although in some cases a persistent symptom, e.g. fever, headache may be captured as a condition before a definitive diagnosis can be discerned by a clinician. By contrast, headache may be captured as an Observation when it contributes to the establishment of a meningitis Condition.* *Use the Observation resource when a symptom is resolved without long term management, tracking, or when a symptom contributes to the establishment of a condition.* *Use Condition when a symptom requires long term management, tracking, or is used as a proxy for a diagnosis or problem that is not yet determined.* *When the diagnosis is related to an allergy or intolerance, the Condition and AllergyIntolerance resources can both be used. However, to be actionable for decision support, using Condition alone is not sufficient as the allergy or intolerance condition needs to be represented as an AllergyIntolerance.* The FHIR R5 guidance in Boundaries and Relationships is the same as R4.0.1. Note that FHIR R5 also has a new resource (maturity level 0) ConditionDefinition– a set of system properties for a particular condition. ▪ ConditionDefinition.observation.category (Observation category value set as a preferred binding). ▪ This new resource doesn't seem to use symptom as a specific factor leading to ConditionDefinition except as an Condition.observation indicating observations particularly relevant to this condition. CURRENT QDM to QI-Core mapping Section 8.22 states:

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			QDM defines Symptom as an indication that a person has a condition or disease. Some examples include headache, fever, fatigue, nausea, vomiting, and pain. Symptoms are subjective manifestations of the disease perceived by the patient. As an example to differentiate symptom from finding, the patient's subjective symptom of fever is distinguished from the temperature (a finding). For a finding, there is either a source of a temperature-measuring device together with a recorder of the device (electronically) or an individual (healthcare provider, patient, etc.). And copies language from the FHIR Condition resource boundaries and relationship. NOTE: "indication" in the first sentence is likely incorrect. Perhaps the paragraph should start with "Symptom is one of several factors that may indicate a person has a condition or disease." ▪ Clinical software will likely identify patient-reported symptoms and clinician identified findings as observations unless the clinician determines the symptom requires long-term management whether or not it has clear causation. – Consistent with the recommendations in the FHIR Condition resource. ▪ In QDM, a generic "observation" uses "Assessment, Performed" – If the clinician has captured the information on a Problem list it MAY be identified as a condition (QDM datatype "Diagnosis") ▪ Consider avoiding the use of "Symptom" in QDM in favor of "Assessment, Performed" and/or "Diagnosis" ▪ Seeking implementer and vendor perspective to learn how evidence of symptoms might be retrieved: – "Symptom" – "Diagnosis" – "Assessment, Performed" – Perhaps the measure should Union "Assessment, Performed" and "Diagnosis" with the same value set for each. – For this example, frailty: ▪ Evaluation tools indicating frailty based on a validated score consistent with a set of observations, use QDM datatype "Assessment, Performed" [Observation in QI-Core] ▪ Consider how to address more subtle, single observations.

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			▪ In QI-Core/FHIR, consider changing the current mapping to Observation.category = symptom – The relevant Observation_category value set has a SHOULD binding but symptom is NOT one of the 9 concepts. **Discussion:** For the NCQA use cases, Howard Bregman (Epic) agreed with using "Assessment, Performed" and/or "Diagnosis". Frequently symptoms are not documented discretely. You may receive false negatives if you use "Symptom". **Resolution/Next Steps:** The User Group did not suggest any changes to QDM. However, the QDM to QI-Core mapping that suggests using Observation.category and assigning a user-defined value of *symptom* should change to ignore the Observation.category element and **not** recommend a specific category code; just reference "Symptom" as an Observation.
20 Minutes	Cumulative Medication Duration QDM-257	Floyd Eisenberg (ESAC)	**Overview:** **QDM recommendations for Cumulative Medication Duration:** **HL7 FHIR related structure:** ● FHIR MedicationRequest includes the element *dosageInstruction* but only references timing as part of that instruction except as a string ● US Core MedicationRequest includes MedicationRequest.dosageInstruction.timing which *can* allow reference to the time a patient is expected to start and stop the medication. ● QI-Core is based on US Core modeling for MedicationRequest which is how the existing QDM maps "Medication, Order" *relevantPeriod*. ● However, such information is rarely, if ever, available in the clinical software from which implementers retrieve data. **QDM Section 5.7 Evaluating Cumulative Medication Duration (CMD)** **5.7.3.1 "Medication, Order"** ● **Currently recommends use of *relevantPeriod* for *startTime* and *stopTime*.** ● **Recommend replacing current suggestion to use attributes:** ○ *daysSupplied* ○ *dosage* ○ *supply* ○ *frequency* ○ *refills*

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			○ *author dateTime [dateTime prescription authored]* ● **Option 1 - use *daysSupplied*:** ○ CMD = daysSupplied, beginning with author dateTime * (1+ #refills) ■ Since daysSupplied addresses a single dispensing event, multiply by (1 + number of refills) ● **Option 2 - when *daysSupplied* is absent, derive it from other existing data:** ○ CMD = [(supply / (dosage * frequency)] beginning with author dateTime * (1+ #refills) beginning with author dateTime * (1+ #refills) ■ *supply* is quantity provided, i.e., number of doses; *dosage* is units per dose; *frequency* is # times per day. Thus, dividing *supply* by (*dosage* times number of times per day) = daysSupplied as a derived value. Then calculation is the same as when daysSupplied is available. **QDM Section 5.7 Evaluating Cumulative Medication Duration (CMD)** **5.7.3.2 "Medication, Dispensed"** ● **Currently recommends use of *relevantPeriod* for *startTime* and *stopTime*.** ● **Recommend replacing current suggestion to use attributes:** ○ *daysSupplied* ○ *dosage* ○ *supply* ○ *frequency* ○ *refills* ○ *relevant dateTime [when dispensing occurred - whenHandedOver in FHIR]* ● **Option 1 - use *daysSupplied*:** ○ CMD = daysSupplied beginning with relevant dateTime (whenHandedOver) ■ Since daysSupplied references a single dispensing event, the measure should identify all dispensing events over the time period desired by the measure (e.g., within 180 days after start of "Diagnosis" *prevalencePeriod* ● **Option 2 - when *daysSupplied* is absent, derive it from other existing data:** ○ CMD = [(supply / (dosage * frequency)] beginning with author dateTime ■ *supply* is quantity provided, i.e., number of doses; *dosage* is units per dose; *frequency* is # times per day. Thus, dividing *supply* by (*dosage* times number of times per day) = daysSupplied as a derived value. Then calculation is the same as when daysSupplied is available. ***relevant dateTime* should be used as the *start date* for "Medication, Dispensed"** with the assumption that medication administration is expected to begin upon receipt.

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			QDM Section 5.7 Evaluating Cumulative Medication Duration (CMD) **5.7.3.3 "Medication, Administered"** ● **Currently recommends use of *relevantPeriod* for *startTime* and *stopTime*.** ● **Available attributes:** ○ *dosage* ○ *frequency* ○ *refills* ○ ***relevant dateTime [single point in time of administration]*** ○ ***relevantPeriod [start and stop of individual administration, e.g., infusion]*** ○ *author DateTime [for time recorded]* ● *relevant dateTime* or *relevantPeriod* may be used as appropriate for a given scenario. For the purpose of medications that can be administered at a point in time or over a period, it may be appropriate to utilize the **normalized interval function** when authoring quality measures. ● "Medication, Administered" is useful for medications administered directly to the patient by a clinician (inpatient or directly observed therapy <DOT>). The CMD needs to identify ALL administration events over the period of time desired to use the first administration *relevant dateTime* or start of the first administration *relevantPeriod* through the last administration during the desired time period. **Examples:** "Medication, Order" 2 tabs 3x/day #180/2 *dosage* = 2 *frequency* = 3x /day (i.e., repeats / period = day) *supply* = 180 *daysSupplied* = 30 days *refills* = 2 derived *daysSupplied* = [*supply* (180) / ((*dosage* (2) x *frequency* (3))] = 30 daysSuppliedWithRefills = [*supply* (180) x (1 + *refills* (2)) / ((*dosage* (2) x *frequency* (3))] = 30 x 3 = 90 days "Medication, Dispensed" 2 tabs 3x/day #180/2***** *dosage* = 2 *frequency* = 3x /day (i.e., repeats / period = day) *supply* = 180 *daysSupplied* = 30 days *refills* = n/a

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			derived *daysSupplied* = [*supply* (180) / ((*dosage* (2) x *frequency* (3))] = 30 "Medication, Order" ½ tab 2x/day #30/2 *dosage* = 1/2 *frequency* = 2x /day (i.e., repeats / period = day) *supply* = 30 *daysSupplied* = 30 *refills* = 2 derived *daysSupplied* = [*supply* (30) / ((*dosage* (1/2) x *frequency* (2))] = 30 daysSuppliedWithRefills = [*supply* (30) x (1 + *refills* (2)) / ((*dosage* (1/2) x *frequency* (2) = 30 x 3 = 90 days "Medication, Dispensed" ½ tab 2x/day #30/2* *dosage* = 1/2 *frequency* = 2x /day (i.e., repeats / period = day) *supply* = 30 *daysSupplied* = 30 *refills* = n/a derived *daysSupplied* = [*supply* (30) / ((*dosage* (1/2) x *frequency* (2))] = 30 "Medication, Order" 5 ml 3x/day #150 ml/0 *dosage* = 5 ml *frequency* = 3x /day (i.e., repeats / period = day) *supply* = 150 ml *daysSupplied* = 10 *refills* = 0 derived *daysSupplied* = [*supply* (150 ml) / ((*dosage* (5 ml) x *frequency* (3)) = 10 days daysSuppliedWithRefills = [*supply* (150 ml) x (1 + *refills* (0)) / ((*dosage* (5 ml) x *frequency* (3)) = 10 days "Medication, Dispensed" 5 ml 3x/day #150 ml/0* *dosage* = 5 ml *frequency* = 3x /day (i.e., repeats / period = day) *supply* = 150 ml *daysSupplied* = 10 *refills* = n/a *daysSupplied* = [*supply* (150 ml) / ((*dosage* (5 ml) x *frequency* (3)) = 10 days

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			***** QDM attributes indicate number of refills for "Medication, Dispensed" but that does not indicate which of 0 to several refills represented by this instance of a dispensing event. Therefore, each dispensing event is evaluated as a separate event and all dispensing events must be considered to determine cumulative medication duration. **Changes as discussed for:** ▪ "Medication, Order" CMD - section 5.7.3.1 ▪ "Medication, Dispense" CMD section 5.7.3.2 ▪ "Medication, Administered" CMD section 5.7.3.3 ▪ And update examples in CMD section 5.7.3.4 ▪ **CONSIDER:** – to avoid inappropriate use, remove *relevantPeriod* from: ▪ "Medication, Order" ▪ "Medication, Dispense" **<u>Discussion:</u>** Ping Jiang (TJC) asked if *daysSupplied* should align with the start of relevant period for Medication, Administered. ESAC suggested administered is a different example. QDM's datatype "Medication, Administration" refers to a single administration event; it is not cumulative across multiple administration events. Peter Muir (ESAC) offered a potential example: if giving a single IM shot that lasts 30 or 60 days, you might use days supplied in the calculation. While reviewing the recording, ESAC suggested that referencing single, monthly IM injections performed by a clinician should be expressed as counting the number of individual "Medication, Administration" events, each of which occurs at a point in time (*relevant dateTime*). However, in the case of self-administered IM administration (by the patient or Care Partner), the expression should use the "Medication, Order" or "Medication, Dispensed" QDM datatypes to determine the CMD, i.e., the *supply* of medication in the vial to be drawn up or the number of pre-filled syringes provided can be used and the individual *dosage* (as mL or pre-filled syringe) with a *frequency* of 1 month to determine the CMD. ESAC suggested it would be useful to hear more examples. Ping offered a scenario for "Medication, Administered" *relevantPeriod* capturing the start of a number of medication administration events with a *start dateTime* and *end dateTime*, not daily administration. ESAC suggested that the definition of *relevantPeriod* is the *start dateTime* and the *stop dateTime* of an individual administration; it does not reference a course of administration events from the first

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			administration to the last. For example, an individual IV infusion is documented with a *start dateTime* and a *stop dateTime*; that is a relevant period. If another dose is given the next day, it has a new *relevantPeriod* for that administration. The *relevantPeriod* in these examples represents timing for each individual "Medication, Administration". ESAC also noted that even for "Medication, Administration" that occurs as an infusion that occurs over a time interval, it may be documented as a single point in time. Therefore, to avoid missing data because of the way they are available in the software, the implementer should evaluate existing implementation practice. If the implementer is unsure how the data will be documented, a **normalized interval** might be best to capture this information. Howard Bregman (Epic) suggested this proposal sounds reasonable. **Resolution/Next Steps:** No attendee raised concerns with adding examples. A final decision about removing *relevantPeriod* from "Medication, Order" or "Medication, Dispense" will be considered at the next QDM User Group meeting on November 18, 2020. ESAC will add this to a potential change for QDM 5.6.
20 Minutes	Adding *relatedTo* attributes QDM-257	Floyd Eisenberg (ESAC)	**Overview:** **QDM currently includes the *relatedTo* attribute for:** ▪ "Care Goal" ▪ "Communication, Performed" ▪ "Assessment, Performed" **Previously added for QDM 5.6 by QDM User Group:** ▪ "Procedure, Performed" **New requests for *relatedTo* attribute:** ▪ "Medication, Order" ▪ "Medication, Dispensed" ▪ "Encounter, Performed" ▪ "Laboratory Test, Performed" ▪ "Physical Exam, Performed" **New requests for *relatedTo* attribute:** ▪ "Medication, Order" and "Medication, Dispensed" – Opioid use measure uses both "Medication, Order" and "Medication, Dispensed" to assure capture of all opioids regardless of where they are ordered.

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			– Need to avoid double counting the same prescription identified by both QDM datatypes. – QI-Core includes MedicationDispense.authorizingPrescription to indicate the dispensing event is related to the prescription – Similarly MedicationRequest.basedOn allows reference to a CarePlan, MedicationRequest, ServiceRequest, or ImmunizationRecommendation as the reason for the order – Adding *relatedTo* for these two datatypes will enable measure expressions to avoid the duplication data issue **New requests for *relatedTo* attribute:** ▪ "Encounter, Performed" ▪ "Laboratory Test, Performed" ▪ "Physical Exam, Performed" **(CMS 529) "Hybrid Hospital-Wide Readmission"** attempts to tie "Laboratory Test, Performed" and "Physical Exam, Performed" to a specific encounter. ▪ Allowing *relatedTo* will enable greater transparency and simpler expressions. ▪ QRDA Category I User Guide provides the following guidance: "This section provides guidance on how to submit the encounter id associated with a core clinical data element for hybrid measure voluntary submission. Association of the data element to the encounter id **uses the Related To (2.16.840.1.113883.10.20.24.3.150:2017-08-01) template** in conjunctions with the "Laboratory Test, Performed" (V5) (2.16.840.1.113883.10.20.24.3.38:2019-12-01) and the "Physical Exam, Performed" (V5) (2.16.840.1.113883.10.20.24.3.59:2019-12-01) templates respectively." **For Discussion:** Grace Glennon (Yale CORE) submitted this request as it relates to a specific use case for the hybrid measure. The developers want to ensure the lab and physical exam results are tied to the encounter as shown in the logic below. Adding *relatedTo* to the Encounter will help achieve this. **Allow for submission of data for this portion of logic:** return { Encounterid: Encounter.id, FirstResult: firstlab.result as Quantity, Timing: firstlab.resultDatetime } return { Encounterid: Encounter.id, FirstResult: firstexam.result as Quantity, Timing: firstexam.relevantDatetime }

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Adding *relatedTo* attributes summary (**Bold**- QDM 5.5 *relatedTo*; Red - new requests)

"Adverse Event"	"Device, Recommended"	"Intervention, Performed"	**"Physical Exam, Performed"**
"Allergy/Intolerance"	"Diagnostic Study, Order"	"Intervention, Recommended"	"Physical Exam, Recommended"
"Assessment, Performed"	"Diagnostic Study, Performed"	"Laboratory Test, Order"	"Procedure, Order"
"Assessment, Order"	"Diagnostic Study, Recommended"	**"Laboratory Test, Performed"**	**"Procedure, Performed"**
"Assessment, Recommended"	"Encounter, Order"	"Laboratory Test, Recommended"	"Procedure, Recommended"
"Patient Care Experience"	**"Encounter, Performed"**	"Medication, Active"	"Related Person"
"Provider Care Experience"	"Encounter, Recommended"	"Medication, Administered"	"Substance, Administered"
"Care Goal"	"Family History"	"Medication, Discharge"	"Substance, Order"
"Communication, Performed"	"Immunization, Administered"	**"Medication, Dispensed"**	"Substance, Recommended"
"Diagnosis"	"Immunization, Order"	**"Medication, Order"**	"Symptom"

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"Device Applied"	"Patient Characteristics"	"Participation"	
"Device, Order"	"Intervention, Order"	"Physical Exam, Order"	

For Discussion:
Maintain *relatedTo* for:
- "Care Goal"
- "Communication, Performed"
- "Assessment, Performed"

QDM User Group previously added (for QDM 5.6):
- "Procedure, Performed"

Consider adding *relatedTo* attribute for:
- "Medication, Order"
- "Medication, Dispensed"
- "Encounter, Performed"
- "Laboratory Test, Performed"
- "Physical Exam, Performed"
- **NOTE:** ANY order or action may require *relatedTo* and QDM only updates once annually. FHIR allows this concept throughout.

Discussion:
Howard Bregman (Epic) suggested the *relatedTo* attribute is ill defined and it is better to time relate to the encounter (i.e., say starts after the start of the encounter).

Grace noted they currently use time to relate to the encounter. The "Laboratory Test, Performed" *relevant dateTime* should be during the start of the "Encounter, Performed" referencing the *result*; however implementer feedback received suggested this approach does not tie the *result* to the specific encounter.

ESAC suggested implementers may be able to indicate that the "Laboratory Test, Performed" *result* is *relatedTo* the "Laboratory Test, Order" if the *relatedTo* attribute were added, and perhaps connect the "Laboratory Test, Order" to the "Encounter, Performed" by timing relationships.

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			However, it might be more difficult to indicate the "Laboratory Test, Performed" is *relatedTo* the "Encounter, Performed". Joe Kunisch (Memorial Hermann) noted their EHR vendor wrote the script for the hybrid measure and did not have any issues capturing the data elements for the hybrid measure. He was unsure about the script, but was not aware of any issues tying the results to the encounter. Jen Seeman (ESAC) noted encounter id is referenced for the next voluntary period for the measure to associate those outside of the timing convention. Adding *relatedTo* would make that clear moving forward. The 2021 QRDA I IG includes content to support how the measure is written for the next voluntary period. Howard Bregman (Epic) suggested simplifying the QDM does not necessarily make it easier for the vendor to find the data. As an example, the strep measure (CMS146) includes complicated logic to identify the strep culture performed and the antibiotics ordered. These are not neatly bucketed in one encounter. The strep test may not be performed in the index encounter. So you might be able to connect the order to the result, but the order might not be easily connected to the encounter. Paul Denning (MITRE) agreed that even though FHIR defines this capability (using Observation.basedOn; it does not make it any easier to find the data in the EHR. Due to the concerns raised about relating lab test to the encounter, the requested approach might not be best way to proceed. Grace Glennon will refer to the approach used in CMS146 as an example for obtaining this information without using the *relatedTo* attribute. ESAC also noted that a laboratory order generated based on what happened during an encounter may actually be ordered after the encounter ends. The same issue exists for physical exam findings. It is not clear that the individual documenting information after the end of an encounter will enter the exact time the observation occurred as distinct from the dateTime (timestamp) of the entry itself. Therefore, timing relationships may be the best way to consider connection between the encounter and a related activity. Note - subsequent to the QDM UG call, an option arose that might include indicating the performer of an order or observation is the same as the practitioner performing the encounter. However, many encounters include multiple individuals (physician, nurse, aide, student, etc) so seeking the same performer id may not be sufficient either. **Resolution/Next Steps:** The User Group did not offer strong support for adding *relatedTo* to any additional datatypes based on the use cases reviewed. There is interest in additional input from measure developers and use cases to support some additions at least for future testing with QDM while moving to FHIR transition.

Time	Item	Presenter	Discussion/Options/Decisions
15 Minutes	Summary QDM 5.6 Changes	Floyd Eisenberg (ESAC)	**Overview:** ▪ Add *relatedTo* attribute to "Procedure, Performed" (previously approved) ▪ Create new *interpretation* attribute for "Laboratory Test, Performed" (previously approved) ▪ Update all definitions and guidance recommended in the QDM v5.5 Guidance Update published in May 2020 (previously approved) ▪ Update Cumulative Medication Duration calculation section (5.7) and create a QDM Known Issue with this information for QDM 5.5.(support for this) ▪ See General Discussion, below, for additional QDM attribute for "Encounter, Performed" – *class* to allow reference to virtual visits similar to the mechanism in FHIR Enounter.class. (support for this change). ▪ Consider retiring *relevantPeriod* for "Medication, Order" and "Medication, Dispensed" (still under consideration) ▪ Add *relatedTo* for: (no support) – "Medication, Order" – "Medication, Dispensed" – "Encounter, Performed" – "Laboratory Test, Performed" – "Physical Exam, Performed" ▪ Consider retiring QDM datatype "Symptom" (remain under consideration) **Reminder:** Please submit feedback via Jira ticket QDM-257 by 5pm November 16, 2020.
5 Minutes	General Discussion	Floyd Eisenberg (ESAC)	**Overview and Discussion:** Paul Denning (MITRE) asked if there is a need in QDM for modifiers to address telehealth encounters. Yvette Apura (ASCO) noted her team is developing a measure that uses telehealth eligible CPT codes (can be used as in-person or telehealth) and they do not know which attribute to use for the telehealth modifiers. ESAC explained that FHIR has an encounter class that allows telehealth visit (code is VR). Implementers would need to map the modifier to the VR code (rather than a CPT modifier). ESAC asked if a *class* attribute in QDM would this help implementers. Jen Seeman (ESAC) noted that when the telehealth guidance was published, there were a handful of tickets from implementers indicating some other ways are in use to indicate a virtual encounter within systems. Paul suggested this aligns QDM with FHIR. Yvette also agreed this would be a useful addition. **Resolution/Next Steps:** The User Group agreed to add the *class* attribute to "Encounter, Performed" to allow specification of virtual visits.

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Next Meeting	Jen Seeman (ESAC)	**Agenda items for next QDM user group meeting** – Contact us at qdm@esacinc.com – Or start a discussion: qdm-user-group-list@esacinc.com *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 QDM@esacinc.com so you may be added to the distribution list.* **Next user group meeting** – November 18, 2020 from 2:30 to 4:30 PM ET.

Invitees/Attendees:

Attended	*Name*	*Organization*
N/A	Abrar Salam	The Joint Commission
N/A	Alex Borenstein	Greenway Health
N/A	Alex Lui	Epic
X	Andy Kubilius	The Joint Commission
N/A	Angela Flanagan	Lantana
N/A	Ann-Marie Dunn	Unknown
N/A	Ann Philips	NCQA
N/A	Anna Bentler	The Joint Commission
X	Anne Coultas	All Scripts
N/A	Anne Smith	NCQA
N/A	Amira Elhagmusa	Battelle
N/A	Balu Balasubramanyam	MITRE
N/A	Ben Hamlin	NCQA
N/A	Benjamin Bussey	Unknown
N/A	Beth Bostrom	AMA
N/A	Brian Blaufeux	Northern Westchester Hospital
N/A	Bidget Blake	MITRE
N/A	Brooke Villarreal	Unknown
N/A	Bryn Rhodes	ESAC
N/A	Carolyn Anderson	Primary care practice
N/A	Chris Moesel	MITRE
N/A	Cindy Lamb	Telligen
X	Claudia Hall	Mathematica
N/A	Corrie Dowell	BSW Health
N/A	Dalana Ostile	Providence Health Systems
N/A	Dawn Lane	Covenant Health
X	Dave Mishler	Care Evolution
N/A	David Brian	Unknown
N/A	David Clayman	Allscripts
N/A	Debbie Hall	University of Maryland
N/A	Debbie McKay	Unknown
N/A	Deidre Sacra	McKesson
N/A	Doug Goldstein	Epic
N/A	Drew Keller	Unknown
X	Evelyn Cody	Mathematica
X	Floyd Eisenberg	ESAC
N/A	Gary Rezik	QIP
N/A	Ganesh Shanmugam	Glenwood Systems
N/A	Gayathri Jayawardena	ESAC
X	Grace Glennon	Yale CORE

Attended	*Name*	*Organization*
N/A	L Dejesus	Informedika
N/A	Lisa Anderson	NCQA
N/A	Lizzie Charboneau	MITRE
N/A	Lynn Perrine	Lantana
N/A	Maggie Lohnes	IMPAQ
N/A	Marc Hadley	MITRE
X	Marc Hallez	The Joint Commission
N/A	Marc Overhage	Cerner
N/A	Margaret Dobson	Zepf Center
N/A	Matt Hardman	Unknown
N/A	Marilyn Parenzan	The Joint Commission
N/A	Martha Radford	NYU
N/A	Melissa Van Fleet	Alliance Health Oklahoma
X	Mia Nievera	The Joint Commission
N/A	Michael Mainridge	Unknown
X	Michael Ryan	NCQA
N/A	Mike Nosal	MITRE
N/A	Michelle Dardis	Mathematica
N/A	Michelle Hinterberg	MediSolv
N/A	Michelle Lefebvre	IMPAQ
N/A	Mike Shoemaker	Telligen
N/A	Mukesh Allu	Epic
N/A	Nathan R	Unknown
N/A	Neelam Zafar	The Joint Commission
N/A	Norm Sirois	Unknown
N/A	Pamela Mahan-Rudolph	Memorial Hermann
X	Paul Denning	MITRE
X	Peter Muir	ESAC
X	Qainta Harris	Arise Medical Center
N/A	Rachel Buchanan	Oregon Urology
N/A	Rayna Scott	PCPI
N/A	R Swaineng	Swaineng Associates
N/A	Rebeccah Baer	NCQA
X	Rhonda Schwartz	ESAC
N/A	Rob McClure	MD Partners
N/A	Rob Samples	ESAC
N/A	Robin Holder	Unknown
N/A	Rose Almonte	MITRE
N/A	Ruth Gatiba	Battelle
N/A	Ryan Clark	NCQA

Attended	*Name*	*Organization*
X	Howard Bregman	Epic
N/A	Huy	Unknown
X	Isbelia Briceno	Cerner
N/A	James Bradley	MITRE
N/A	Jamie Lehner	PCPI
N/A	Jana Malinowski	Cerner
N/A	Janet Wagner	Unknown
X	Jen Seeman	ESAC
N/A	Jennifer Distefano	Unknown
N/A	Jenna Williams-Bader	NCQA
N/A	Jill Shuemaker	VCU Health
N/A	John Carroll	The Joint Commission
N/A	John Lujan	Kaiser Permanente
N/A	Jessica Smails	Caradigm
N/A	Joe Bormel	Cognitive Medicine
X	Joseph Kunisch	Memorial Hermann
N/A	Johanna Ward	Mathematica
N/A	Jorge Belmonte	PCPI
N/A	Julie Koscuiszka	Nyack Hospital
N/A	Juliet Rubini	Mathematica
N/A	Justin Schirle	Epic
N/A	Jay Frails	Meditech
N/A	Katie Magoulick	CMS
X	Kathy Carson	SemanticBits
N/A	Kim Sweat	Unknown
N/A	Kimberly Smuk	HSAG
N/A	KP Sethi	Lantana
N/A	Latasha Archer	NCQA
N/A	Laura Pearlman	Midwest Center for Women's Healthcare
N/A	Laurie Wissell	Allscripts

Attended	*Name*	*Organization*
N/A	Ryan Guifoyle	Unknown
N/A	Samuel Benton	NCQA
N/A	Sarah Sims	My Patient Insight
N/A	Sethuraman Ramanan	Cognizant
N/A	Shanna Hartman	CMS
N/A	Stan Rankins	Telligen
N/A	Susan Wisnieski	Meditech
N/A	Syed Zeeshan	eDaptive Systems
N/A	Tammy Kuschel	McKesson
N/A	Tess Rayle	Unknown
N/A	Thomas Hudson	Unknown
N/A	Tom Dunn	Telligen
X	Traci Psihas	ESAC
N/A	Vaspaan Patel	NCQA
N/A	Ward Holland	Unknown
N/A	Wendy Wise	Lantana
X	Yan Heras	ESAC
X	Yanyan Hu	The Joint Commission
N/A	Yiscah Bracha	RTI
X	Yvette Apura	ASCO
N/A	Zahid Butt	MediSolv
N/A	Zeeshan Pasha	Unknown
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A