Quality Data Model (QDM) User Group Meeting |Minutes

Meeting date | *12/19/2018 2:30 PM ET* | Meeting location|Webinar link:
https://esacinc2.webex.com/esacinc2/j.php?MTID=me8d6277dca528e02526f28ca60f9397b

Time	Item	Presenter	Discussion/Options/Decisions

5 Minutes	Announcements	Chana West (ESAC)	• **New and Improved eCQI Resource Center Website Available**
			  ○ The eCQI Resource Center has updated its look and feel to promote a more user-friendly experience based on feedback from the community. The redesign aligns with the Quality Payment Program (QPP) website to promote continuity amongst CMS resources. The update also simplifies navigation and presents eCQI resources and information in a more manageable and meaningful way.
			• **Now Available: Updated CMS QRDA I Conformance Statement Resource for Hospital Submissions**
			  ○ CMS has updated the QRDA Category I Conformance Statement Resource to support Calendar Year 2018 eCQM reporting for the Hospital Inpatient Quality Reporting (IQR) and Medicare and Medicaid Promoting Interoperability (PI) programs.
			  ○ The Conformance Statement Resource assists data submitters to troubleshoot the most common conformance errors by providing detailed information to resolve the errors causing the file to be rejected.
			• **Now Available: Addendum to the 2018 CMS QRDA I Implementation Guide for Hospital Quality Reporting**
			  ○ CMS has published an addendum to the 2018 CMS Quality Reporting Document Architecture (QRDA) Category I Implementation Guide (IG), originally published in July 2017.This addendum includes six new conformance statements specific to CMS programs and updates the description of one other conformance number.
			  ○ The IG provides technical instructions for QRDA Category I reporting for eligible hospitals and critical access hospitals reporting electronic clinical quality measures for the calendar year 2018 reporting period for the Hospital IQR and PI Programs.

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5 Minutes, Cont.	Announcements, Cont.	Chana West (ESAC), Cont.	• **Now Available: Sample Hybrid Hospital-Wide Readmission Measure QRDA I File for Hospital IQR Voluntary Reporting**
			  ○ CMS) has released a sample Quality Reporting Document Architecture (QRDA) I file for reporting the voluntary Hybrid Hospital-Wide Readmission (HWR) Measure under the Hospital IQR Program.
			  ○ The Hybrid HWR measure was developed to address complex and critical aspects of care that cannot be derived through claims data alone. Hospitals can voluntarily submit data for this measure and participation will not impact payments to hospitals.
			• The sample QRDA Category I file for the Hybrid HWR measure, 2018 CMS QRDA I IG and addendum are available for download on the Electronic Clinical Quality (eCQI) Resource Center QRDA page

60 Minutes	Consider adding Performer, Requester, Participant and Practitioner as attributes to enable attribution [QDM-218]	Floyd Eisenberg (ESAC)	**Overview:** To address attribution, measures may need to identify the provider who performed a procedure (numerator criterion) is the same provider associated with the encounter (denominator criterion). QDM includes a "source" attribute (a dataflow attribute) but it does not specify performer; rather, it specifies the informant of the information who may be a performer but is not necessarily so. This request is to consider more comprehensively adding “performer” as an attribute to many datatypes to the extent that standards support it. Note that Medication, Order *prescriber* and Medication, Dispensed *dispenser* were added to QDM 5.4 to allow measures to evaluate all medications of a certain class ordered by a specific prescriber. To further evaluate performers of actions in measures, it might be helpful to identify if the individual who performed a task (a) is the same as the individual who performed the encounters to meet the measure denominator, or (b) is a member of the practice in which those encounters occurred. There is currently no way in QDM to say anything about the performer of an action except for medication ordering or dispensing. Further, to address attribution, those reporting on measures may need to first identify the group (e.g., a practice, a CPC+ group, etc.) that is being measured and determine if actions taken are performed by members of that group. To accommodate these use cases, the proposal under consideration is add “performer” as an attribute to datatypes to the extent that standards support it. Note, that HL7 FHIR STU 3 and STU 4 allow specification of performers for Procedures, Observations, participants for Encounters, requesters for Requests (orders or recommendations), owners for Tasks, and practitioners for Immunizations (i.e., the practitioner administering the immunization). That would allow the following attributes to be supported in QDM:

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60 Minutes, Cont.	Consider adding Performer, Requester, Participant and Practitioner as attributes to enable attribution [QDM-218], Cont.	Floyd Eisenberg (ESAC), Cont.	• Requester Id
			  ○ Procedure, Recommended
			  ○ Procedure, Order
			  ○ Laboratory Test, Recommended
			  ○ Laboratory Test, Order
			  ○ Diagnostic Study, Recommened
			  ○ Diagnostic Study, Order
			  ○ Assessment, Recommended
			  ○ Assessment, Order
			• Performer Id
			  ○ Assessment, Performed
			  ○ Laboratory Test, Performed
			  ○ Diagnostic Test, Performed
			  ○ Physical Exam, Performed
			  ○ Procedure, Performed
			• Participant Id
			  ○ Encounter, Performed
			• Practitioner Id
			  ○ Immunization, Administered
			• Note – DeviceUseStatement has no “performer” concept, possibly because DeviceUseStatement is a unique message and, therefore, can use FHIR Provenance to determine the author.
			• Alternatively, QDM could use the same attribute name (e.g., *performer*) for all QDM datatypes and map individually to each FHIR resource noted.
			HL7 FHIR STU 3 and STU 4 also support identifiers for practitioners and for organizations as Provider.id to enable identification of an individual or organization that is the subject of measurement.
			
			Detailed Discussion:
			• Greta Kessler - Has scenarios where the measure needs to know if two encounters were performed by same provider, which is slightly different than the performer against a group. Will this allow this provider equals this provider?
			• ESAC suggested that is one level of intent. There are two levels: determine attribution to a single provider or to a larger group where the group is defined locally or by the program.

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60 Minutes, Cont.	Consider adding Performer, Requester, Participant and Practitioner as attributes to enable attribution [QDM-218], Cont.	Floyd Eisenberg (ESAC), Cont.	• Joe Kunisch (Memorial Hermann) - Asked if this is going to be limited to specific things like encounters, because the physician attribution space on inpatient side is complicated. A hospital patient is seen by many providers. Will this be limited to ambulatory domain where it is more clear who the group/provider is? • ESAC suggested that is a question for the user group to consider and also for each measure developer to consider in designing individual measures. Should QDM enable these attributes for every type of QDM action datatype or limit to particular types? If either case, it is up to the measure developer to understand all the implications for individual measures and settings. • Greta Kessler - Is this the person who entered information about a procedure in the system or the person who performed the surgery, etc.? ESAC noted that the individual FHIR resource can identify the performer of that action as a data element. FHIR provenance can identify the author of a message. This concept is similar to consolidated CDA in which the author of the summary c-CDA is identified in the header of the c-CDA but the performer or author of each concept within the summary is specified by the c-CDA representation of that component concept. Hence, DeviceUseStatement does not have its own author as the statement may be a message. As defined in QDM 5.4, the process of placing a device should reference a Procedure, Performed; hence, the procedure would have a performer. • ESAC –If we asked for a *performer* identifier, would vendors be able to find it? • Howard Bregman (Epic) - Sometimes; often no. Often in team-based care, one person is performing an action but representing another person. • ESAC noted every measure developer would have to test with sites to see if evaluation by performer is feasible. • Joe Kunisch (Memorial Hermann) - Suggested the biggest issue is the accuracy. There is a lot of work behind mapping it and keeping up with changing provider ids to make sure mapping is accurate. Physician, nursing and other staff changes occur throughout the year making mapping to a group identified would be complex and could add significant burden. • Yiscah Bracha (RTI) - Noted that lack of a basic group identifier is problematic for CPC+ practices because individual clinicians participating in groups may be members of larger groups. The same patient is seeing other providers using the same EHR and, thus, the practice's performance rate is impacted by the behavior of the other providers who are not members of the group being measured. This issue is the original impetus for introducing this concept. The impact is measure-specific. Not every measure needs this level of granularity.

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60 Minutes, Cont.	Consider adding Performer, Requester, Participant and Practitioner as attributes to enable attribution [QDM-218], Cont.	Floyd Eisenberg (ESAC), Cont.	• An example of a measure that might benefit from including providerId is one in which the denominator expects the same patient to see the same provider twice to be member of the population. If the provider is a member of a team, that mapping could occur during implementation, but it depends on the use case. • Jan Malinowski (Cerner) - Noted transitioning data from the QDM into the QRDA becomes complicated especially with requirement of the export and import of QRDA I files if some of these discrete data elements are not present. ESAC showed an example of a CQL expression that might assure that two unique providers are part of a larger *attributionId* grouping: Example CQL Expression from ["Encounter, Performed": "Inpatient"] Encounter1, ["Encounter, Performed": "Inpatient"] Encounter2, ["Provider"] Provider1, ["Provider"] Provider2 where Encounter1 !~ Encounter2 and Encounter1.performerId = Provider1.id and Encounter2.performerId = Provider2.id and Provider1.attributionId = Provider2.attributionId In this example, two different encounters are each performed by a different provider, and the group to which Provider1 belongs is the same group to which Provider2 belongs. • Greta Kessler - there are times when I need to see if something happened by the same provider from the same organization. For example, a Procedure, performed occurs and the provider had to communicate the reports to someone else. We would want the same provider id on the Communication, Performed and on the Procedure, Performed. • Howard Bregman (Epic) - Noted in team-based care, a patient is seen by nurses, medical assistants, and physicians and counseled for tobacco use. Who did the counseling? It may not be the physician, but someone else on the team. Would this be a failure? • ESAC noted that in this example if you indicate that all those providers are part of the attribution set, the counseling would be counted. It is also important to note that the example provided does not need to use the performerId or attributionId since the measure cares only if the action (i.e., counseling) occurred within the time bound Encounter, Performed. It is only where the measure must specify the performer of an action to avoid attributing

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60 Minutes, Cont.	Consider adding Performer, Requester, Participant and Practitioner as attributes to enable attribution [QDM-218], Cont.	Floyd Eisenberg (ESAC), Cont.	undesired occurrences to providers/groups when the actions were performed by non-group members. • Yiscah Bracha (RTI) – For CPC+, in order to participate in the program the PCP has to provide CMS with a roster of participating providers. This mapping of individuals to the group exists because it is part of the participation agreement. During implementation it is possible to map an individual to the group based on how that group was defined at the time of the action's occurrence. • Ben Hamlin (NCQA) - Suggested a measure developer would not ever want to maintain lists of providers in a measure algorithm. Adding complexity to measure specifications that does not belong. ESAC explained part of the rationale was not for a measure developer to specify the members of the group in the measure, but to allow the measure to indicate that for the group being measuring, locally identify the group attributionId and its individual members such that the calculation can be performed. The proposal is to allow the measure metadata to allow someone analyzing the results to do so. • Ben Hamlin (NCQA) - In our attribution we stick to group definition, like a physical practice location. • ESAC confirmed the measure developer would not identify the list. This is done outside the measure. • Joe Kunisch (Memorial Hermann) - Noted someone must maintain those groups. • Rob McClure (NLM Contractor) - issue is that some of the measures there is interest in determining whether one of the member of a group has done something in terms of the attribution for the individual member being assessed. There are other measures where it doesn't matter who did something, that it was just done. Sometimes the interest is only when done by one of the people inside this group. When a drug is prescribed or some activity done and in particular when it is not what was intended. There are situations when the measure developer would want to say we care about when someone in your group has done something, and not when something done by someone outside of the group. The complexity is onerous and presumably this segmentation is occurring anyway. The identifier is not reported, but the numerator and denominator are collecting the proper patient data. • ESAC agreed the main issue is when being in the numerator is a negative in which providers want the result of the measure to be as close to zero as possible. The concern is if someone outside of the group does something that includes them in the numerator, then those in group get negative rating when they in fact had nothing to do with it.

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60 Minutes, Cont.	Consider adding Performer, Requester, Participant and Practitioner as attributes to enable attribution [QDM-218], Cont.	Floyd Eisenberg (ESAC), Cont.	• Ben Hamlin (NCQA) - This is not the responsibility of measure developer, but rather a QI activity. The measure is following clinical guidelines. This should not be discussed in context of measure numerator and denominator. • Yiscah Bracha (RTI) - Noted the attribution at level of individual versus group. At the individual level, there is still a problem. For example, high risk meds in elderly where patient gets into second numerator if the patient received two prescriptions for the same high-risk med. If the orders are from different prescribers across the organization, there still needs to be a way to say you did it or you did not do it. This problem of localizing responsibility to a single individual is the problem we are trying to solve by extending the concept of prescriber id. • Howard Bregman (Epic) - The issue is that even if you give developers these attributes, they would not use it. The measure is put into a program by CMS with certain rules. The combination of the measure and the rules is what would cause this to happen. Not convinced this suggestion moves towards that goal. This is a program issue. • Ben Hamlin (NCQA) - If two practitioners prescribe high risk meds, the measure does not absolve either practitioner for not being part of the practice. Measure says these are high risks meds that should not be on these concurrently. This is a program issue. • Rob McClure (NLM Contractor) - Noted there is an opportunity to improve in that the measure developer has responsibility to be clear where the measure is best applied. This issue needs to be clarified. Therefore, if an organization reports on the measure, they take responsibility that the analysis done by the measure can be reported back properly. One approach is that certain organizations, based on their ability to query data and report back, would choose to not do the measure because they cannot properly differentiate participating from non-participating members and, among the participating members, how to improve care based on the report. • Yiscah Bracha (RTI) - Noted within CMS programs, sometimes it is an individual being measured and sometimes it is a group. It all depends on the program they are participating in. You cannot assume all measures are being used to assess performance at the organization level. • Rob McClure (NLM Contractor) - Suggested putting the onus on the measure developer who needs to explain the impact of using that measure in different scenarios. Maybe even suggest the requirements to use the measure. • Ben Hamlin (NCQA) - but then this puts the onus on measure developer to try to anticipate

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60 Minutes, Cont.	Consider adding Performer, Requester, Participant and Practitioner as attributes to enable attribution [QDM-218], Cont.	Floyd Eisenberg (ESAC), Cont.	all possible uses for the measure. • Greta Kessler - Means we have to understand all business models and decide whether the measure applies to it. That's impossible. • Rob McClure (NLM Contractor) - Suggested measure developers clearly indicate how it works best. • Yiscah Bracha (RTI) - High risk meds in the elderly provides an example. There is a statement in the guidance that the intent is that the same individual provider issues the same prescription. That statement in the guidance is not reflected in the specification, so clinicians reading the front page only see guidance they interpret as 'I am only responsible for myself', but when the data come back they discover the results show the provider is responsible for everyone seeing the patient in the EHR. Believe prescriber id would solve that problem for that measure. ESAC further explained how this might be implemented. Instead of provider characteristic, do we change to provider with the attributes of ID, attribution ID, and qualification codes to identify the provider is a certain type (OBGYN), and possibly identify gender. Sometimes you may want to know if the provider is of a certain specialty. Do we have a performer for every datatype? Do we enhance provider by enabling other types of calculation? • Joe Kunisch (Memorial Hermann) - Because multiple scenarios were brought up on this call, it might be useful to read through those to ensure we all fully understand the issue. Suggested this will create considerable burden in some cases and will only support if it has clear constraints. Otherwise, if measure developers are left to their own interpretation, it will create issues. • Peter Muir (ESAC) - Suggested on measure CMS156 high risk meds, he reported on a group basis, but also runs on a provider basis and trend by provider. Trying to put that level of detail into the measure will be a hassle to maintain. The provider characteristics, particularly if mapped to an MPI, do it through MPI rather than in the measure as that is too burdensome. Additionally, the team performs task and may run everything through his number. Trying to coordinate that is too burdensome. Also, this level of detail would delay getting measures implemented, and for these reasons it is best to keep it simple. Break it down by practice, MPI and trend it. This is useful to providers. • Rob McClure (NLM Contractor) - Agreed this would be beneficial, where understood.

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60 Minutes, Cont.	Consider adding Performer, Requester, Participant and Practitioner as attributes to enable attribution [QDM-218], Cont.	Floyd Eisenberg (ESAC), Cont.	Howard Bregman (Epic) - Regarding the second issue, not sure we know the gender of providers. Specialty gets into a difficult area because some have multiple specialties. This is mixed complexity that's not workable. **Summary:** 1. Measures cannot define attribution groups. Programs in which measures are used define such groups (i.e., individuals or practices or organizations for which the measure is appropriate. 2. Individuals, practices or organizations need to review each measure to determine if their data sources might impact their results and decide on measures that will not be impacted by potentially extraneous data. E.g., if the EHR data includes information from inpatient and ambulatory settings a measure intended for ambulatory practices may be impacted by data from the inpatient setting. In such situations the organization may decide not to report on such a measure. 3. Practices provide care in teams. Any one individual in the team may perform a task required by the measure. Defining who provided which task creates complexity in implementation since teams change frequently through a measurement period (personnel changes, reassignments, etc.). Even defining an "attribution group" is complex since the composition changes over the period of the performance. CPC+, for example, changes the patient "membership" several times through the year making attribution for a full year performance period difficult. 4. Clear use cases and workflows have not been provided. The User Group took no action on adding performers for individual QDM datatypes or for a Provider attribution ID. QDM User Group members are invited to provide some use cases and considerations for further discussion. **Resolution/Next Steps:** The QDM User Group does not support this change at this time. It might be useful to identify relevant use cases and bring this back to this group for discussion. Those with specific use cases should bring those forth for discussion at a future meeting.

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15 Minutes	Consider adding clarification around negation rationale (single point in time [QDM-219])	Floyd Eisenberg (ESAC)	**Overview:**
			The submitter asked about having a Relevant Period for Negation Rationale because QDM states that one can have a Relevant Period or Author dateTime.
			QDM Statement: "Note: Some datatypes include both Relevant Time and author dateTime attributes. The purpose is to accommodate Author dateTime if the actual start and stop times are not available when evaluating for feasibility, and also to allow specification of a time for Negation Rationale."
			The actual intent was that author dateTime could be used when relevant times are not available and the author dateTime is used for negation rationale.
			Does anyone disagree that negation rationale should only be limited to author dateTime?
			No one disagreed.
			Need to change wording to reflect the intent.
			ESAC proposed rewording the statement in the next version of QDM to say:
			• Negation rationale always uses the author dateTime attribute to reference timing.
			• Consider that other activities reference timing as:
			  • Testing reveals that RelevantPeriod startTime is present even if endTime is not - use RelevantPeriod
			  • There is no RelevantPeriod because the action is referenced only as attestation that it occurred (e.g., a procedure documented as an observation - use Assessment, Performed and author dateTime).
			ESAC also proposed adding a Known Issue to indicate that negation rationale always uses author dateTime.
			
			Discussion:
			Lisa Anderson (TJC) - Agreed to reword the statement. Suggested it might not make sense to add the additional information about relevant period in the negation rationale section. ESAC clarified that that paragraph will be added to every datatype that has a relevant period and an author time explaining why it has both.
			Joe Kunisch (Memorial Hermann) - Agreed to add Known Issue.

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15 Minutes, Cont.	Consider adding clarification around negation rationale (single point in time [QDM-219]), Cont.	Floyd Eisenberg (ESAC), Cont.	**Resolution/Next Steps:** The QDM User Group agreed it makes sense to add a Known Issue to clarify negation rationale wording. [Note: In the subsequent December 20, 2018 eCQM Working Group call (a meeting of measure developers working on measures), modification to the language for the Known Issue was accepted: "Negation of QDM datatype-related actions for a reason always use the author dateTime attribute to reference timing. RelevantPeriod does not apply to negated QDM datatype-related actions."

Time	Item	Presenter	Discussion/Options/Decisions
30 Minutes	Consider Adding Present on Admission as an attribute for Encounter, Performed (diagnosis) [QDM-220]	Floyd Eisenberg (ESAC) / Zahid Butt (Medisolv)	**Overview:** The Diagnosis Present on Admission (POA) is an indicator assigned to Inpatient Encounter Diagnosis and is used extensively in quality and patient safety measures. POA Indicators include: • Y - Yes, diagnosis present on admission • N - No, diagnosis not present on admission • U - documentation insufficient to determine if present on admission • W - Provider unable to clinically determine whether diagnosis present on admission The POA indicator is required for all diagnosis that are not referenced in the POA exempt list published periodically by CMS. References: Hospital-Acquired Conditions (Present on Admission Indicator): https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html. Hospital-Acquired Conditions (Present on Admission Indicator) – Coding: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html Note: the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Measures [https://www.qualityindicators.ahrq.gov/Modules/list_ahrq_qi.aspx] also include the concept of Present on Admission although none is currently expressed as an eCQM. QDM Issue Tracker Request (from MediSolv): • Add QDM attribute for PresentOnAdmission • Currently, the UB-04 Field locators 67 and 67-AQ may represent the fields used for these POA indicators as additions to the diagnosis codes. Two related QDM attributes: • Diagnosis – Since Diagnosis includes specific information inherent to the diagnosis, POA would not apply as a Diagnosis attribute. POA is a specific indicator about diagnoses addressed within an encounter. • Encounter, Performed – The *present on admission* context is an additional *sub*-attribute to Encounter.diagnosis. **Discussion:** ESAC – Where is the Present On Admission indicator present in the EHR? Howard Bregman (Epic) – On the UB-04 claim Rob McClure (NLM Contractor) - is it possible that this indicator is included on any diagnosis included in the claim?

Time	Item	Presenter	Discussion/Options/Decisions
30 Minutes, Cont.	Consider Adding Present on Admission as an attribute for Encounter, Performed (diagnosis) [QDM-220], Cont.	Floyd Eisenberg (ESAC) / Zahid Butt (Medisolv), Cont.	Howard Bregman (Epic) - there is a subset of exempt diagnoses and it is pretty large Justin Di Stefano (MediSolv) - We get this from our data pulls. From a measure standpoint, there is no way to represent *Present on Admission* with the current QDM mappings. It is referenced in a number of places and it makes sense to include the concept in measures. Joe Kunisch (Memorial Hermann) - Also brought this issue up in the past. The concept is important when trying to determine if sepsis was present on admission or occurred subsequent to admission. Currently, hospitals have to use proxy data elements to make the determination. Support this concept. Howard Bregman (Epic) – The source is only what is on the claim. In Epic, the physician can flag a diagnosis being present on admission but one cannot rely on physician's to add the flag consistently. The indicator will always be on the claim. It is important only to be able to specify to use the billing diagnosis and the Present on Admission indicator attribute specifically. Lisa Anderson (TJC) - Suggested if we represent in QDM it sounds like it would be an attribute of the Diagnosis attribute that is part of the Encounter datatype. ESAC looked in FHIR for possible mappings and found diagnosis billing. There is a way to indicate type of diagnosis but you would have to add it as a present on admission diagnosis. Rob McClure (NLM Contractor) - Suggested it is best to make an extension rather than stick into a value set which is already universally appropriate. Adding an extension and incorporating into the HL7 FHIR QI Core profile is preferred. This indicator is specific to the US Realm and it exists in claims so it does not need to be added to the HL7 FHIR US Core. ESAC proposed adding a new attribute of the Encounter diagnosis (attribute of an attribute): "Diagnosis present on admission". Rob McClure (NLM Contractor) - Suggested this mimic what is in UB-04. Add a present on admission (POA) indicator with the same options on the UB-04 (i.e., Y, N, U, W) and spell out "Present On Admission Indicator". Paul Denning (MITRE) - Noted it is unclear how an attribute of an attribute will be implemented. ESAC suggested the model info enables this in the CQL. ESAC will confirm. **Resolution/Next Steps:** The QDM User Group agreed to include this proposal to add a Present On Admission (POA) indicator with the specific values from the UB-04 in the docket for consideration for the next version of QDM. This new attribute is limited to Encounter, Performed. To avoid confusion with acronyms, the attribute should be named "PresentOnAdmissionIndicator" and it should be used as a "sub-attribute" to Encounter, Performed *diagnosis* since the indicator is always present in conjunction

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30 Minutes, Cont.	Consider Adding Present on Admission as an attribute for Encounter, Performed (diagnosis) [QDM-220], Cont.	Floyd Eisenberg (ESAC) / Zahid Butt (Medisolv), Cont.	with an existing encounter diagnosis. The source of such data is always the UB-04 claim form and measure developers should be restricted to the available indicators identified by that form (Y - yes, N - no, U - documentation insufficient information to determine, and W - clinically undetermined). Measure developers can reference the required "PresentOnAdmissionIndicator" response appropriate for their respective measures in the CQL expressions. ESAC to confirm how to design attribute of attribute in the CQL.
2 Minutes	QI Core – Update (HL7 CQI Workgroup)	Floyd Eisenberg, (ESAC)	QI Core STU 3.2.0 Update Review site: • Adds Encounter and PractitionerRole profiles now included in FHIR US Core • Updates QDM to QI Core mappings The final review is Friday, 12/21, during the HL7 CQI WG meeting. If accepted, it will be voted upon potentially for publication. Build site: http://build.fhir.org/ig/cqframework/qi-core/index.html
2 Minutes	QDM Medication Class for Allergies [QDM-188]	Robert McClure, NLM Contractor	Anne Coultas (Allscripts) - Asked for clarification regarding using SNOMED codes for medication class for allergy. • Rob McClure (NLM Contractor) -The Governance Group discussed this issue and agreed that SNOMED CT was a good code system to use to represent a drug class. • Claudia Hall (Mathematica) - Noted for the upcoming Annual Update, two measures will pilot this approach. • Lisa Anderson (TJC) - Noted there is a one-year transition period. For the next annual update cycle, they are adding a value set that represents medication as a class in addition to the current value set. Will do this for one year and then solicit feedback from implementers to determine if the next cycle is a good time to remove the previous value set. This allows those on RxNorm to continue using it next year. No further action is required from the QDM User Group.

Time	Item	Presenter	Discussion/Options/Decisions
2 Minutes	Next Meeting	Chana West (ESAC)	**Agenda items for next QDM user group meeting** – Contact us at gdm@esacinc.com – Or start a discussion: qdm-user-group-list@esacinc.com **Next user group meeting** – **OFF-CYCLE** Meeting – January 23, 2019 2:30pm – 4:30 PM ET *(Please manually update your calendars)* Retrieve the Calendar Year 2019 meeting appointments from the eCQI Resource Center events page

Invitees/Attendees:

	Name	Organization
	Abrar Salam	The Joint Commission
	Andy Kubilius	Unknown
	Angela Flanagan	Lantana
X	Ann Philips	NCQA
	Anna Bentler	The Joint Commission
X	Anne Coultas	Allscripts
X	Anne Smith	NCQA
	Balu Balasubramanyam	MITRE
X	Ben Hamlin	NCQA
X	Beth Bostrom	AMA
X	Bob Keyes	Unknown
X	Bill McDougal	Unknown
	Brian Blaufeux	Northern Westchester Hospital
	Bryn Rhodes	ESAC
X	Chana West	ESAC
	Chandra Bartleman	Telligen
	Chris Moesel	MITRE
	Cindy Lamb	Telligen
X	Christopher Heinz	Unknown
X	Claudia Hall	Mathematica
	Corrie Dowell	BSW Health
	Cynthia Barton	Lantana
	Dalana Ostile	Providence Health Systems
	Dave Wade	Apprio
	Debbie Hall	University of Maryland
	Deidre Sacra	McKesson
	Doug Goldstein	Epic
X	Floyd Eisenberg	ESAC
	Ganesh Shanmugam	Glenwood Systems
X	Greta Kessler	Premier
X	Howard Bregman	Epic
	Hyok-Hee Yoo	Medisolv
X	Isabella Briceno	Cerner
X	Jana Malinowski	Cerner
X	Joseph Kunisch	Memorial Hermann
	Jorge Belmonte	PCPI
	Julia Skapik	ONC
	Julie Koscuiszka	Nyack Hospital
X	Juliet Rubini	Mathematica
X	Justin Di Stefano	MediSolv
	Justin Schirle	Epic
	Jay Frails	Meditech
	Kari Snyder	Unknown
	Kendra Hanley	HSAG
	Kimberly Smuk	HSAG

	Name	Organization
	Laura Pearlman	Midwest Center for Women's Healthcare
	Laurie Wissell	Allscripts
	Lindsey Clapper	Unknown
X	Lisa Anderson	The Joint Commission
	Lizzie Charboneau	MITRE
X	Lynn Perrine	Lantana
	Marc Hadley	MITRE
	Marc Overhage	Cerner
	Maria Johnson	Unknown
	Margaret Dobson	Zepf Center
X	Marilyn Parenzan	The Joint Commission
	Martha Radford	NYU
	Matt Hardman	Unknown
	Melissa Van Fleet	Alliance Health Oklahoma
X	Mia Nievera	The Joint Commission
	Michelle Dardis	The Joint Commission
	Michelle Hinterberg	MediSolv
X	Mike Shoemaker	Telligen
	Mukesh Allu	Epic
	Neelam Zafar	The Joint Commission
	Pam Finley	Unknown
	Pamela Mahan-Rudolph	Memorial Hermann
	Patty McKay	FMQAI
X	Paul Denning	MITRE
X	Peter Muir	ESAC
	Rachel Buchanan	Oregon Urology
	Rayna Scott	PCPI
	Rebeccah Baer	NCQA
X	Rob McClure	NLM Contractor
	Rob Samples	ESAC
	Rose Almonte	MITRE
	Rukma Joshi	ESAC
	Rute Martins	MITRE
	Ryan Sullivan	NYU
	Syed Zeeshan	eDaptive Systems
	Tammy Kuschel	McKesson
X	Thoma Hudson	Parkview Health
	Tom Dunn	Telligen
	Vaspaan Patel	NCQA
	Wendy Wise	Lantana
X	Yan Heras	ESAC
X	Yanyan Hu	The Joint Commission
X	Yiscah Bracha	RTI
X	Zach May	ESAC
X	Zahid Butt	MediSolv