QDI User Group Meeting Notes August 19, 2026

Meeting Name	**Quality Data Implementation (QDI) User Group**
Recording	To improve notetaking, an audio recording of the discussion is desired. The recording will be used internally to ensure accuracy. Please alert us to any objections at the start of the meeting. Thank you.
Meeting Information	**Microsoft Teams** Need help? **Join the meeting now** Meeting ID: 297 443 617 546 00 Passcode: h54HD983
Meeting Purpose	The QDI User Group is established to provide a collaborative, multi-stakeholder forum to guide the development, implementation, maintenance, and harmonization of quality data models used in healthcare quality measurement and improvement.
Meeting Facilitator	Angela Flanagan, eCQI Standards Team
Meeting Date	**Meeting Date:** August 19, 2026 **Meeting Time:** 3 PM ET

Meeting Notes

Opening & Announcements

Meeting called to order by Angela Flanagan.

Session recorded for internal documentation.

Participants invited to join distribution list via eCQI@lantanagroup.com.

Purpose: Collaborative discussion on quality data model development, implementation, and alignment.

Agenda Overview

(1) **Not Done (performed, requested) and rationale data;**

(2) **One clinical concept/multiple FHIR representations;**

moved to next meeting-

(3) **Timing and episode-of-care ambiguity;**

(4) **Clinically important data trapped in narrative; and**

(5) **Provenance and data-source reliability.**

Discussion Items

QDI User Group Meeting Summary — August 19, 2026

The August QDI User Group meeting focused on what was described as the **"last mile" of digital quality measurement**—the point where measure specifications, FHIR representations, and real-world clinical workflows must come together. The group's purpose was reinforced as bringing vendors, measure developers, and implementers together to improve clarity, consistency, reusability, and implementability of quality data models.

The meeting was designed to move from broad discussion toward more concrete implementation scenarios. Five areas were identified for continued exploration: **"not done" and rationale data, multiple FHIR representations for the same clinical concept, timing and episode-of-care ambiguity, clinically important data retained in narrative text, and provenance/data-source reliability.** Because of time, the discussion concentrated primarily on the first two areas and related medication, diagnosis, and problem-list examples.

Not Done / Not Performed / Rationale Data

The group examined how measures can reliably determine not only that an activity did not occur, but **why** it did not occur. Examples included a medication not given because of an allergy, an incomplete PHQ-9, and a patient declining a colonoscopy. These scenarios demonstrated that "not done" is not a single concept: it may represent refusal, contraindication, inability to assess, allergy, cancellation, or another rationale, and the information may be stored differently depending on the workflow.

Participants described substantial variation in actual EHR documentation. For inpatient medications, "not given" may be available as a discrete MAR field, whereas a medication never ordered because of a known allergy may be captured only in the allergy record or narrative documentation. Some systems provide discrete cancellation reasons, including allergic reaction, but local configurations and available choices may vary by organization.

A recurring concern was **workflow burden**. Although EHRs may offer quality-specific structured forms, clinicians may prefer their normal progress-note workflows. Participants noted

that more detailed structured documentation often requires alerts, education, and continued follow-up to obtain consistently.

For common assessments such as the PHQ-9, participants reported that patient refusal is more commonly available as structured data. They also raised the distinction between **refusal and inability to assess**, such as when a patient is confused or unable to respond, as well as circumstances in which a caregiver completes an assessment. These scenarios may require additional terminology or mapping so that measure logic does not treat all missing assessments alike.

For preventive procedures, participants described discrete "patient refused" options in some health-maintenance workflows. However, they also noted that measure logic does not always recognize refusal as an allowable exception. CMS130 was specifically raised as an example where patient refusal does not remove a patient from the measure, prompting discussion about whether measure developers should consider such situations more consistently.

The group ultimately framed the **Not Done bottom line** as determining the minimum computable information necessary to reliably state that a specific action did not occur, for a particular reason, in a particular clinical context. The measure should require only the level of rationale specificity, event linkage, and timing actually needed for its clinical intent, rather than creating additional documentation solely for measurement.

Outside Records and Scanned Documents

A significant related problem involved services performed outside the organization. Mammograms, colonoscopies, diabetic eye exams, and other procedures may arrive as PDFs or scanned documents. Although clinicians know the service occurred, the performed date and other measure-relevant information may never become discrete data. Participants described reliance on HIM staff to create an order, label or attach the scanned document, or otherwise transfer information into structured fields. When that workflow fails, quality scores may not reflect the care actually received.

This was characterized largely as a **workflow and data-capture problem rather than a lack of clinical information**. The information exists, but it is not available to automated measure calculation in a consistently computable form.

One Clinical Concept, Multiple FHIR Representations

The group then explored situations where the same clinical event can be represented in multiple FHIR resources. Mammography was used as the primary example. Evidence that a mammogram occurred could potentially appear through an Observation, DiagnosticReport, Procedure, ImagingStudy, claim/EOB, or another representation. Each resource may describe a different aspect of the episode—such as acquisition of images, performance of the procedure, or the final interpretation—so the resources are not automatically interchangeable.

Participants generally supported allowing **more than one clinically valid representation** when the measure intent can be satisfied by different systems in different ways. Limiting logic to one resource could undercount valid care. At the same time, retrieving every conceivable representation could create duplicate counting or broaden the measure beyond its intended clinical meaning.

A key principle emerged: **flexibility should remain within the semantic meaning of the FHIR model.** Participants cautioned against accepting a resource merely because an organization happens to place the data there if that representation does not appropriately convey the intended concept. The goal should therefore be a judicious set of acceptable representations rather than "accept everything."

Another important recommendation was **cross-program harmonization**. If several quality programs are attempting to determine whether the same clinical event occurred, participants favored using consistent FHIR representations and requirements rather than requiring organizations to implement slightly different approaches for essentially the same concept.

"Active Medication" and Clinical Intent

The discussion used "active medication" to illustrate how a seemingly simple term can have several meanings. It might mean that a medication was prescribed, appears on the medication list, was dispensed, was administered, or is reported by the patient as currently being taken. These represent different clinical facts.

Participants emphasized that measure developers should therefore avoid relying on the broad phrase **"active medication"** without defining the intended evidence. If the measure is asking whether a medication was ordered, MedicationRequest may be appropriate. If the question is whether it was administered, MedicationAdministration may be more meaningful. If the question is whether a patient reports currently taking it, another representation may be needed.

A Joint Commission example reinforced this approach: the measure selects specific medication resources based on whether the intent is an inpatient order, discharge medication, or actual administration rather than attempting to infer a generic "active medication" concept.

Diagnosis Representation and Supporting Evidence

Colon cancer was used to illustrate a related problem. A diagnosis can generate evidence across Observations, DiagnosticReports, ImagingStudy, Condition/problem list, encounter diagnoses, and claims. These resources may represent findings, supporting evidence, an encounter-specific diagnosis, or an established clinical condition—not necessarily the same fact.

The discussion reinforced that the appropriate representation depends on **measure intent**. If the intent is an established active condition, Condition may be most appropriate. If the intent is a diagnosis associated with a hospitalization, an encounter or claim diagnosis may be more relevant. If the measure needs supporting evidence, laboratory, imaging, pathology, or other

findings may appropriately contribute. Timing is also critical because onset, recorded date, effective time, issued date, and claim timing represent different things.

Participants also raised the example of newer blood-based colorectal cancer testing. One participant reported that current measure logic did not recognize a newer blood-based test being used in practice, resulting in lower reported performance even though screening was occurring. This illustrated the broader need for measure specifications and terminology to keep pace with evolving clinical practice.

Problem List and Data Quality

The group returned to a recurring concern: sometimes the **quality of the underlying data is a larger problem than the FHIR representation itself**. Problem lists may retain outdated diagnoses because providers do not update them, staff are uncomfortable removing information, or organizations disagree about who owns problem-list maintenance. Participants described efforts involving task forces, education, policies, and limiting nursing/MA edits to duplicate entries, but no simple solution emerged.

One participant gave an example of an obviously incorrect diagnosis remaining on a record for years because staff were hesitant to remove it without provider confirmation. This reinforced the challenge of data stewardship and ownership.

Bidirectional HIE and FHIR exchange can further complicate the problem. Imported problem, allergy, medication, and immunization information can create duplicate or conflicting entries that must be reconciled. Participants noted that without designated staff and adequate workflow support, reconciliation may not be completed consistently.

Medication reconciliation provided a concrete example: even when organizations use standardized terminology such as RxNorm, minor textual differences may result in multiple apparently duplicate entries being presented to users for manual reconciliation. Participants expressed interest in vendors doing more to identify equivalent information before it reaches the clinician.

Overall Takeaway

The strongest theme from the meeting was that **the clinical intent should come first, and the FHIR representation should follow from that intent**. Measures need enough flexibility to recognize legitimate differences in EHR implementation, but that flexibility cannot be so broad that clinically different concepts become interchangeable.

Across the examples, participants repeatedly returned to four needs: clearer definitions of the clinical event being measured; identification of the minimum data needed to establish that event; support for multiple semantically appropriate representations when necessary; and real-world testing to determine whether those representations are actually available and usable without creating unreasonable documentation burden.

Several of the originally planned “last mile” topics—particularly timing/episode-of-care ambiguity, narrative data, and provenance/data-source reliability—were not fully reached because of time and remain candidates for future meetings.

Next steps:

Participants were asked to continue thinking about the open implementation questions and bring additional real-world examples to future calls.

A participant survey was distributed to help determine future QDI topics and meeting format. Measure-specific questions should continue to be submitted through the eCQI JIRA tracker, and proposed agenda topics can be sent eCQI@lantanagroup.com

Participant Survey Provided

QDI User Group Participant Feedback Survey – Fill out form

Reminder to us ONC Jira for measure specific questions
https://oncprojectracking.healthit.gov/

Request for agenda items prior to next meeting September 16, 2026

Next Meeting

Date: Wednesday, Septebmer 16, 2026
Time: 3:00 PM Eastern Standard Time

Agenda items may be submitted to **ecqi@lantanagroup.com**.

Participants were encouraged to share future meetings with colleagues.

Action Items

Attendance: 83 Attendees

Attendee	Attendee
Abhishek Jaiswal	Katie M Yarber
Aguilar, Sheila	Kelsey Pence (Unverified)
Alannah Marsh	Kent, Britt
Angela Flanagan	Kerri Nelson
Anita Russell	KOUTCHAPOVA, ANNA
Anne Marie Smith	Kris Done

Arens, Stacey	Lani Smith
Arvind Jagannathan	Lewis, Jill
Banskota, Abhilasha [Epic ClinDoc]	Lisa Melanson
Bartelheim, Cara	Lynn Perrine
Belarmino, Raquel	Magoulick, Katie
Ben Allaire	Martha Stoner
Bialecki, Brian	Massotto, Denise R
Bradshaw, Susan R	McKenzie, Deanna
Bridwell, Adam M.	Ming Dunajick
Bryn Rhodes (Unverified)	Morgan, Sheree
Butler, Karen	Morgan,Jeremy
Chen, Elaine	Moriah Bauman
Cyr, Penny	Nayaab Baig
Darnell Boudreaux	Nelson, Shanelle
Davis, Julie A	Nicole Rabic
Dawson, Julia	Northrup, Christina L.
Delbridge,Emily	Paramasivam, Arunkumar
Donnell Gonzales	Randig, Sharyn
Dorothy Lee	Roberts, James
Elizabeth Stanbridge (Unverified)	Sarah J. Rathert
Esterline, Kristy L.	Schufman, Miranda A
Fevola, Summer	Shaian Preihs (Unverified)
Hageman, Jen	Shaian Preihs (Unverified)
Hager, Alison	Shardae Sims
Heiler, Andrew	Snow, Amanda T
Hernan Sierra	Subhan, Hafsa
Hu, Yanyan	Sweta Shah
Hugo Andrade	Tammy Gettinger
jackie (Unverified)	TINA Jean

Jason Evans (Smile) (Unverified)	Van, Cindy
Jennifer Seeman	Webster, Charles
Jessica Saddler	Wilbers, Jennifer
Joann Igney	Willeman, Patricia
JoAnn Saporito	Yetter, Kathleen S (US)
Kadel, Sunita	Zhen Lin
Karen McLaughlin	