QDI User Group Meeting Notes September 16 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:** 16 Sep 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;**

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

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

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

Announcements

Cooking with CQL, QDM, and FHIR® Webinar This meeting occurs the third Thursday of every month.

MADiE User Group Thu, 09/17/2026 - 02:00PM EDT This group meets the third Thursday of every month.

HL7 40th Annual Plenary, Working Group Meeting and HL7 FHIR Connectathon
September 19 - 24, 2026 • Rockville, Maryland

Discussion Items

QDI User Group Meeting Summary — September 16, 2026

The September QDI User Group meeting continued the **"last mile" of digital quality measurement** discussion: situations where clinically meaningful information exists, but may not be consistently captured, structured, represented, or reusable for FHIR-based dQMs. The primary focus of this meeting was **timing and episode-of-care ambiguity**. Clinically important data in narrative and provenance/data-source reliability were identified as agenda topics, but the discussion remained largely focused on timing and episode-of-care issues.

Timing and Episode-of-Care Ambiguity

A central theme was that clinicians often perceive a patient's care as **one continuous clinical episode**, while EHRs and measure logic may represent that care through multiple encounters, statuses, locations, resources, and timestamps. A patient may move from ED to observation to inpatient care and then to the ICU, with each transition potentially represented differently depending on the organization and EHR implementation.

Participants emphasized two fundamental questions:

1. **When did the clinically meaningful event occur?**
2. **Which encounters and events belong to the same episode of care?**

The discussion reinforced that the appropriate answer depends on the **clinical intent of the measure**, rather than simply selecting whichever timestamp is easiest to retrieve.

ED → Observation → Inpatient Representation

Participants described how their organizations represent transitions among ED, observation, and inpatient status. An Oracle Cerner user explained that these phases may ultimately be treated as **one visit or encounter for billing purposes**, while the system retains the times associated with each status. The final classification may depend on the patient's status at discharge.

This creates a challenge when measure logic asks whether something occurred **before the inpatient encounter**. Participants questioned whether "before inpatient" means before formal inpatient status or before the patient arrived for the broader episode of care. In some cases, several days of ED and observation care can occur before inpatient status begins.

From the measure-development perspective, participants discussed hospitalization logic that may use ED or observation start time when those encounters immediately precede inpatient admission, including logic using a one-hour relationship between encounters. If neither ED nor observation precedes the inpatient stay, the hospitalization starts with the inpatient admission.

Outpatient STEMI Example

The outpatient STEMI measure was raised as a concrete example of episode ambiguity. Participants reported difficulty determining whether a PCI or other intervention occurred during the ED portion of care or after inpatient status began when the EHR represents the overall visit as one encounter. One participant reported that this ambiguity had affected the accuracy of their reported data.

Another participant explained that a provider may place the inpatient admission order either before or after the cath-lab intervention. As a result, essentially the same clinical care could be categorized differently depending on the timing of the admission order. Participants also noted that third-party systems may not send all of the necessary timing information back to the primary EHR consistently.

This discussion highlighted a broader tension between **historical program/billing definitions** and increasingly clinical, computable definitions used by eCQMs and dQMs.

Clinical Episode vs. Billing Status

Participants repeatedly returned to the question of whether quality measures should be organized around:

- billing status,

- individual ED/observation/inpatient segments, or
- the patient's overall clinical episode.

One participant noted that historically inpatient and outpatient quality populations were closely tied to IPPS and OPPS billing populations. With digital measures, those distinctions may no longer align neatly with the way clinical care is being evaluated. Participants called for greater clarity about whether a measure is evaluating a **specific status** or the **overall hospitalization/clinical process**.

A related suggestion was to take a more **patient-centric view of care**, rather than treating ED, observation, and inpatient services as isolated silos when the measure is intended to evaluate a continuous clinical process. Pregnancy was offered as another example where measurement may need to span prenatal, hospital, and postpartum care.

Terminology Matters: "Admission," "Encounter," and "Transfer"

Participants found that even common terms can be interpreted differently.

"Admission" was identified as particularly ambiguous. A measure developer may use "hospital admission" to mean the beginning of inpatient status, while clinicians and implementers may hear "admission" as movement out of the ED into either observation or inpatient care. Participants recommended using more precise, consistent terminology when the measure specifically means inpatient status.

"Encounter" can also mean different things. Measure specifications may treat ED, observation, and inpatient periods as separate encounters, while an EHR or healthcare organization may refer to the entire visit as one encounter for operational or billing purposes.

"Transfer" was similarly identified as potentially ambiguous. Moving from one unit to another within the same hospital is different from transfer between separate hospitals, and the clinically meaningful concept may be the **level of care provided**, rather than physical location alone.

Choosing the Correct Timestamp

The group emphasized that a single clinical event can legitimately have many timestamps, including:

- arrival time,
- admission order time,
- observation start,
- inpatient start,
- procedure performed time,
- result time,
- report finalization,
- documentation time, and
- claim timing.

All may be valid, but they answer different clinical questions. The measure should therefore explicitly identify the timestamp that represents the **clinical event of interest**.

An example of a colonoscopy illustrated the issue. The procedure itself may occur on March 3, while the report is signed March 4, pathology results become available March 6, a diagnosis is entered March 7, and a claim is submitted later. Participants generally supported using the **actual procedure date** when the measure is asking when the colonoscopy was performed, rather than using subsequent documentation or result dates as substitutes.

Participants also noted that the correct timestamp may depend on the question. If a measure asks when a procedure occurred, the performed time is appropriate; if it asks when a result became available to influence care, a result or finalization time may be more meaningful.

Preliminary vs. Final Results

Blood cultures were used to illustrate that **clinical action may occur before a final result is available**. A provider may begin treatment based on a preliminary result, while the final culture result may not be available for another 48 hours. Participants emphasized that measure logic should reflect the clinical intent and relevant standard of care rather than assuming the final-result timestamp is always the meaningful one.

Cross-Organization Transfers

The group also discussed transfers between hospitals. Participants generally viewed a transfer from Hospital A to Hospital B as two separate organizational episodes, with each facility accountable for the care provided within its own setting. However, the care provided at the sending organization may still be clinically relevant to measures evaluated at the receiving organization, depending on measure intent.

This reinforced the need to distinguish **within-hospital transitions** from **cross-organization transfers**.

Resource and Element Definitions - Education

A participant asked where implementers can find definitions for FHIR elements such as Encounter.classHistory, Encounter.location.period, Encounter.partOf, and related concepts. The discussion identified the applicable implementation guides, including US Quality Core, as resources for understanding resource and element definitions and their intended use.

This led to a broader discussion about an educational gap. Participants noted that clinicians, quality professionals, vendors, logic authors, and measure developers do not necessarily share the same level of knowledge about FHIR, implementation guides, and CQL. One participant suggested that education aimed at **end users and quality professionals**, positioned between highly technical CQL training and measure-specific webinars, could improve understanding and help healthcare organizations better evaluate vendor implementations.

Overall Takeaway

The strongest conclusion from the meeting was that **timing and episode definitions are part of the clinical meaning of the measure, not merely technical implementation details**.

The group repeatedly emphasized that measure specifications should make clear:

- whether logic applies to a specific encounter/status or the entire hospitalization;
- what event establishes the start and end of the relevant interval;
- which timestamp represents the clinical event;
- how ED, observation, inpatient, and location transitions relate;
- and whether program/billing classifications are relevant to the measure's clinical intent.

The broader "last mile" takeaway was that having clinical information somewhere in the record does not automatically make it **computable, interoperable, or fit for digital quality measurement**.

The group also recognized that **not every implementation problem should be solved by adding complexity to measure logic**. Greater consistency may instead require clearer implementation guidance, standardized data representation, improved terminology, or agreement about which information vendors should expose.

Follow-Up / Next Steps

The meeting identified several practical follow-ups:

- Include references to the applicable implementation guides so participants can locate definitions for common FHIR resources and elements.
- Consider additional education designed for quality professionals and other users who need to understand measure specifications and FHIR concepts but are not CQL authors.
- Continue examining whether terminology such as **admission, encounter, hospitalization, and transfer** is sufficiently precise and consistently understood.
- Encourage measure developers to clearly identify whether timing relates to a specific encounter/status or the broader episode of care.
- Route measure-specific questions through the **eCQM Issue Tracker** and general CQL language questions through the **CQL Issue Tracker**.
- Continue submitting real-world QDI topics and scenarios for future sessions to the eCQI team.

The meeting closed with the goal of making digital quality measurement not only technically computable, but also **clinically meaningful, consistently implementable, interoperable, and less burdensome**.

Next Meeting

Date: Wednesday, October 21, 2026
Time: 3:00 PM Eastern Standard Time

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

Please share future meetings with colleagues.

Attendance: 41 Attendees

Attendee	Attendee
Angela Flanagan	Kassandra Davis
Jen Seeman	Magoulick, Katie
Blauvelt, Jacqui A	Diana (Unverified)
Ostlie, Dalana	Sara Esperti
Aguilar, Sheila	Nelson, Shanelle
Hu, Yanyan	Shardae Sims
McLennan, Angela (CMS/CCSQ)	Yan Heras (Unverified)
Kim Smuk	Sellappan, Vidya (CMS/CCSQ)
Banskota, Abhilasha [Epic ClinDoc]	Cecilia Wilson
Grant, Gail P., M.D.,MPH, MBA	Yetter, Kathleen S (US)
Belarmino, Raquel	Michelle Ashafa
Webster, Charles	Nicole Rabic
Burlison, Kelly	Jason Evans - Smile (Unverified)
McKenzie, Deanna	Sudol, Magdalena A
Kent, Britt	Jiang, Ping
14087555115 (Unverified)	Lisa Melanson
Erin Lee	Anne Marie Smith
Nayaab Baig	Dorothy Lee
Anderson, Lisa	Van, Cindy
Sera Gearhart	Sarah J. Rathert
Lefebvre, Michelle	