Quality Data Model (QDM) User Group Meeting | Minutes

Meeting date | *08/19/2020 2:30 PM ET* | Meeting location|Webinar https://esacinc2.webex.com/esacinc2/j.php?MTID=mb664f23602ec7fedf8287ada56865428

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Announcements	Jen Seeman (ESAC)	• There is no Cooking with CQL session for August, will resume in September. • Next QDM User Group Meeting is scheduled for September 16, 2020 [**Note:** Subsequent to this QDM User Group call, the September 16, 2020 meeting was cancelled since follow up for the topics discussed on this August 19 meeting require consideration of HL7 Working Group Meeting discussions during the week of September 21-25. The next QDM User Group Meeting will occur October 21, 2020.]
30 Minutes	Defining Primary versus Principal Diagnosis	Floyd Eisenberg (ESAC)	**Overview:** Encounter Diagnosis Use Case Some HL7 discussions have considered how to address an encounter-related *primary* diagnosis. The use case is to unite the payor "claims world" and the patient's view, specifically allowing the patient to see the same *primary* diagnosis on their clinical visit summaries and the Explanation of Benefit (EOB) form referencing the same encounter. Note that the clinical encounter diagnosis in FHIR uses Encounter.diagnosis and the EOB data original with FHIR's Claim.diagnosis. Some discussions for HL7 C-CDA efforts suggested identifying a *primary* diagnosis for this use case as a substitute for the *principal diagnosis* that currently exists with C-CDA work. They are concerned about our use of Encounter.diagnosis.*rank* and Encounter.diagnosis.use (with role = billing diagnosis) to identify a principal diagnosis. To assist with understanding the difference between *principal* and *primary* diagnosis, the following clinical scenario takes a patient with osteoporosis through a hospitalization for hip replacement surgery.

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FHIR Evaluation for QI-Core: Encounter diagnosis example scenario

Clinical scenario	Encounter.diagnosis.use (*role*) Claim.diagnosis.type (*type*)	Primary diagnosis (*role* or *type* with *rank*, or *sequence* = 1)	Principal diagnosis
Patient admitted with osteoarthritis for hip replacement	Admitting (either osteoporosis condition or hip replacement procedure)	Osteoarthritis (Admitting diagnosis with rank =1)	Osteoarthritis (Billing diagnosis with rank =1)
Patient has cardiac event (Atrial fibrillation) – surgery cancelled	Comorbidity or Clinical diagnosis – atrial fibrillation	Atrial fibrillation (Comorbidity or clinical diagnosis with rank =1)	Osteoarthritis (Billing diagnosis with rank =1)
Patient has stroke (secondary to atrial fibrillation; atrial fibrillation subsequently controlled)	Comorbidity or Clinical diagnosis – cerebrovascular ischemic event	Cerebrovascular ischemic event (Comorbidity or clinical diagnosis with rank =1)	Osteoarthritis (Billing diagnosis with rank =1)
Patient discharged to rehab	Discharge diagnosis – cerebrovascular ischemic event with sequelae; atrial fibrillation	Cerebrovascular ischemic event with sequelae (Discharge diagnosis with rank =1)* * May change later by coders to = principal diagnosis	Osteoarthritis (Billing diagnosis with rank =1)

To understand how FHIR, and specifically US Core represents a encounter diagnosis, ESAC presented information available un US Core to determine reason for an encounter.

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			FHIR Evaluation for QI-Core – US Core Encounter US Core STU 3.1.1 (for FHIR R4 – 4.0.1) – Encounter profile Each Encounter **must have**: ▪ A status ▪ An classification such as inpatient, outpatient or emergency ▪ An encounter type ▪ A patient Each Encounter **must support**: ▪ An encounter identifier ▪ Providers involved in the encounter ▪ When the encounter occurred ▪ **Reason for the visit [note – this is not the same as Encounter.diagnosis]** ▪ The discharge disposition ▪ Where the encounter occurred Profile specific implementation guidance: ▪ To search for an **encounter diagnosis**, query for Condition resources that reference the Encounter of interest and have a category of encounter-diagnosis. An example search is shown in the Condition Quick Start section. These elements can be viewed in the Differential View for what US Core Encounter MUST SUPPORT: HL7 FHIR US Core Structure Definitions-Encounter Further detail in US Core about how to use Encounter.reasonCode to determine a *primary* diagnosis: ▪ US Core – MUST SUPPORT US-Core-R4 Encounter.reasonCode – Definition: Reason the encounter takes place – expressed as a code. For admissions, this can be used for a coded admission diagnosis. – The diagnosis can be coded using Encounter.reasonCode: CodeableConcept and SHOULD be taken from valueset-encounter-reason (SNOMED clinical findings, procedures, context-dependent categories, events). – However, there is no Encounter.*use* or Encounter.*role* to specify a primary, principal, billing or other diagnoses. To do that, US Core Profiles refer to Extensions: ▪ Registry of standard extensions that can be found in the FHIR specification ▪ Additional extensions may be registered on the HL7 FHIR registry at HL7 FHIR Registry

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– FHIR Conformance path and search for *primary*, leads to: FHIR Registry-API-open structure definitions.
– The JSON assigns a *sequence* to the diagnosis and it *can* be a billing diagnosis, but *sequence* is not detailed.

[Note – FHIR Claim includes a Claim.diagnosis.sequence; FHIR Encounter includes Encounter.diagnosis.rank – both with similar, but different definitions.]

US Core STU 3.1.1 (for FHIR R4 – 4.0.1)

- US Core **does not** specifically support Encounter.diagnosis which *does* have Encounter.diagnosis.rank (similar to sequence) and Encounter.diagnosis.use that allows specifying the role (admitting, discharge, billing, etc.).
- QI-Core includes Encounter.reasonCode *and* took the path of Encounter.diagnosis with its respective *use, rank* and added *PresentOnAdmission* parallel to Claim.diagnosis.
- US Core 3.1.1 - FHIR-28186
- Claim tracker - FHIR-28187
- Encounter tracker - FHIR-28188

See HL7 Jira ticket 10544 for FHIR STU 3
"The encounter-primaryDiagnosis and encounter-relatedCondition extensions will be removed, as they are now redundant, and represented in the core resource." (i.e., existed in FHIR STU 3, removed in R4) HL7 FHIR Jira ticket 10578

Comparison of value sets used for FHIR R4 Encounter.diagnosis and Claim.diagnosis

Encounter.diagnosis.use – diagnosisRole value set		Claim.diagnosis.type – diagnosticType value set	
Code	**Display**	**Code**	**Display**
AD	Admission diagnosis	admitting	Admitting Diagnosis
DD	Discharge diagnosis	clinical	Clinical Diagnosis
CC	Chief complaint	differential	Differential Diagnosis
CM	Comorbidity diagnosis	discharge	Discharge Diagnosis
pre-op	pre-op diagnosis	laboratory	Laboratory Diagnosis
post-op	post-op diagnosis	nursing	Nursing Diagnosis
billing	Billing	prenatal	Prenatal Diagnosis

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		principal	Principal Diagnosis
		radiology	Radiology Diagnosis
		remote	Remote Diagnosis
		retrospective	Retrospective Diagnosis
		self	Self Diagnosis

Claim and Encounter also have two similar concepts defined a bit differently:

- Claim.diagnosis.sequence (R4 - A number to uniquely identify diagnosis entries, R5 – *instance identifier*)
- Encounter.diagnosis.rank (R4 – Ranking of the diagnosis (for each role type), R5 – No change)

Further discussions planned during the upcoming HL7 virtual Working Group Meeting in September about Encounter Diagnosis:

- Monday, September 21
  Patient Care call 2-4 PM ET
- Thursday, September 24
  Cross-Group Project call 2-4 PM ET
- Friday, September 25
  Financial Management call 12-2 PM ET

HL7 CQI Workgroup September 2020 Virtual WGM Agenda

Discussion:

Rob McClure (MD Partners) noted it is important to understand what is meant by Principal Diagnosis and there is value in having the same code and code system in both the clinical summary and the EOB. The groups should harmonize, clearly state what is meant by principal and ensure the value sets meet the needs of individual implementers. Joe Kunisch (Memorial Hermann) suggested mapping is determined at the local level. Ultimately, it will be defined by the measure developer. For example, for a lab diagnosis, if no field exists, the software will extract the principal diagnosis because that's why they have the lab results. Rob agreed and suggested it is important to let HL7, CMS, and other stakeholders know about the challenges associated with allowing for all these differences. Joe suggested it is important that the workgroups include a coder when considering steps forward. Lisa Anderson (NCQA) asked if the Structured Docs working group is involved in these discussions. ESAC indicated the topic arose from work in the

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			Examples Task Force (CDA) and Structured Documents when that group looked at QRDA's use of encounter diagnosis rank for principal diagnosis. Lisa Nelson (Max.md) brought the issue to the HL7 Clinical Quality Information (CQI) Workgroup and she has been invited to bring other stakeholders in the patient summary primary diagnosis discussions to the HL7 Working Group Meeting sessions noted above. **Resolution/Next Steps:** The CQI agenda is available at: HL7 CQI Workgroup September 2020 Virtual WGM Agenda. Following the discussions at the HL7 Working Group Meeting, the QDM User Group will review options (October QDM User Group meeting).
30 Minutes	Referencing Telehealth Visits	Floyd Eisenberg (ESAC)	**Overview:** The change in healthcare delivery during the current pandemic led to a significant change to telehealth visits. CMS provided a list of visit codes that can be used for in-person or virtual visits and eCQM developers determined which of the measures that used those visit codes could be reported and which would represent a significant departure from measure intent. ESAC provided a reference to how a virtual visit might be expressed in FHIR with QI-Core and asked about implications for QDM. QDM's datatype "Encounter, Performed" attributes do not include any attribute specific to virtual visit. Generally, measure developers interested in specific visit types use the encounter value set to represent it. Current "Encounter, Performed" attributes: • *relevantPeriod* • *admission source* • *diagnoses* (3 components) - *diagnosis (code)* - *presentOnAdmissionIndicator (code)* - *rank* • *discharge disposition* • *length of stay* • *priority* • *author dateTime* • *code* • *id* • *facility locations* (may appear 0 or many times) (Each component will have:

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- *code*
- *locationPeriod)*

- *participant*

QDM to QI-Core Mapping includes the follow, using Encounter.class to indicate a visit type that can be virtual. But it may need to be re-evaluated:

- ”Encounter, Performed” *code*: Encounter.class using v3ActEncounterCode/vs

v3ActEncounterCodes

Code	Display	Definition
AMB	ambulatory	A comprehensive term for health care provided in a healthcare facility (e.g. a practitioner, aTMs office, clinic setting, or hospital) on a nonresident basis. The term ambulatory usually implies that the patient has come to the location and is not assigned to a bed. Sometimes referred to as an outpatient encounter.
EMER	emergency	A patient encounter that takes place at a dedicated healthcare service delivery location where the patient receives immediate evaluation and treatment, provided until the patient can be discharged or responsibility for the patient's care is transferred elsewhere (for example, the patient could be admitted as an inpatient or transferred to another facility.)
FLD	field	A patient encounter that takes place both outside a dedicated service delivery location and outside a patient's residence. Example locations might include an accident site and at a supermarket.
HH	home health	Healthcare encounter that takes place in the residence of the patient or a designee
IMP	inpatient encounter	A patient encounter where a patient is admitted by a hospital or equivalent facility, assigned to a location where patients generally stay at least overnight and provided with room, board, and continuous nursing service.
ACUTE	inpatient acute	An acute inpatient encounter.
NONAC	inpatient non-acute	Any category of inpatient encounter except 'acute'

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OBSENC	observation encounter	An encounter where the patient usually will start in different encounter, such as one in the emergency department (EMER) but then transition to this type of encounter because they require a significant period of treatment and monitoring to determine whether or not their condition warrants an inpatient admission or discharge. In the majority of cases the decision about admission or discharge will occur within a time period determined by local, regional or national regulation, often between 24 and 48 hours.
PRENC	pre-admission	A patient encounter where patient is scheduled or planned to receive service delivery in the future, and the patient is given a pre-admission account number. When the patient comes back for subsequent service, the pre-admission encounter is selected and is encapsulated into the service registration, and a new account number is generated. Usage Note: This is intended to be used in advance of encounter types such as ambulatory, inpatient encounter, virtual, etc.
SS	short stay	An encounter where the patient is admitted to a health care facility for a predetermined length of time, usually less than 24 hours.
VR	virtual	A patient encounter where the patient and the practitioner(s) are not in the same physical location. Examples include telephone conference, email exchange, robotic surgery, and televideo conference.

However, “Encounter, Order” and “Encounter, Recommended” map differently:

- “Encounter, Order” *code*: ServiceRequest.code using ValueSet-us-core-procedure-code (CPT, SNOMED-CT, HCPCS Level II alphanumeric codes)
- “Encounter, Recommended” *code*: ServiceRequest.code using ValueSet-us-core-procedure-code (CPT, SNOMED-CT, HCPCS Level II alphanumeric codes)

Most eCQMs now use the same value set for all three (performed, order, recommended):

- ”Encounter, Performed” *code*: procedure codes (**not** Encounter.class codes)
- “Encounter, Order” *code*: procedure codes (similar to ServiceRequest.code)

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			▪ "Encounter, Recommended" *code*: procedure codes (similar to ServiceRequest.code) Blueprint recommendations (Table 17) is consistent with the current approach in eCQMs "Encounter, Order"; "Encounter, Performed", "Encounter, Recommended" – SNOMED CT procedure (transition – CPT, HCPCS, ICD-9 Procedures, ICD-10 CM, ICD-10 PCS) Therefore, the current QDM to QI-Core mapping for "Encounter, Performed" *code* to class might be incorrect and it is inconsistent with current practice. **ESAC asked the User Group to consider the following change for QDM to QI-Core mapping:** ▪ Map QDM "Encounter, Performed" *code* to Encounter.type with value set ValueSet-us-core-encounter-type (SNOMED CT descending from the concept 308335008 (Patient encounter procedure (procedure)) and from the Current Procedure and Terminology(CPT) designated for Evaluation and Management (99200 – 99607) (subscription to AMA Required)) ▪ Reference Encounter.class as a **new element** (not in QDM as an attribute) to define v3ActEncounterCode/vs ▪ **CONSIDER** – do existing EHRs share "Encounter.class" information and should QDM 5.6 add an "Encounter, Performed" *class* attribute to allow different types of visits? **Discussion:** Lisa Anderson (NCQA) asked if a new attribute called "Encounter.class" would support modifier codes to indicate a telehealth visit. ESAC believes the FHIR value set binding is extensible to allow use of such modifier codes. Joe Kunisch (Memorial Hermann) was not sure and would need to investigate how it is captured. Mia Nivera (TJC) asked about capturing emergency and virtual or ambulatory and virtual visits. For example, a telehealth visit from the emergency department of the hospital to the paramedics in the patient's home. ESAC suggested in this case the encounter type is most likely ER visit with the class as virtual. Mia then asked what the purpose of the emergency definition is within the class. ESAC suggested there may be some overlap in definitions in the value set shown and harmonization of concept representation might be a good topic to raise with the Patient Administration Workgroup, the owner of the FHIR Encounter resource. Yan Heras noted for QRDA, Encounter Performed, encounter code is an HL7 Version 3 datatype which allows the qualifier, with the name of virtual. You select encounter code and indicate it is virtual. **Resolution/Next Steps:** ESAC will raise the issue of reconciling encounter class and type with the Patient Administration

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			workgroup. The User Group will consider whether it makes sense to add another attribute to QDM, or whether it is more reasonable to leave QDM as is and modify the QI-Core mappings as noted in the discussion. Plan for reviewing again at the October 2020 QDM User Group meeting after the HL7 virtual Working Group Meeting in September.
30 Minutes	Expressing Imaging Studies in QI Core	Floyd Eisenberg (ESAC)	**Overview:** The Joint Commission asked about the appropriate terminology to reference an imaging study with QI-Core, i.e., an imaging study that has a result (to indicate it was performed) but without specifying what should be the result. ESAC initiated the discussion by indicating how QDM and QDM to QI-Core mapping would address a result as an observation: **Blueprint terminology recommendations (Table 17)** "Assessment, Performed" ▪ *code** (i.e., the observable entity question) – LOINC ▪ *result* (i.e., the answer to the question) – SNOMED CT (disorders, findings) *or* LOINC normative responses "Diagnosis Study, Performed" • *code* (i.e., the test name) • *result* (i.e., the findings from the study) – SNOMED CT (disorders, findings) *or* LOINC normative responses **FHIR Evaluation for QI-Core – QI-Core STU 4 Observation Use Case** **Evaluate newborn care –** eCQM evaluating if a newborn had a CT scan or MRI done during the encounter. It does not look for a specific result,only that one exists. ["Diagnostic Study, Performed": "Moderate Neurological Complications"] BrainScan where BrainScan.result is not null **For FHIR transition, which QI-Core resource is appropriate? There are two QI-Core resources to consider:** ▪ ImagingStudy resource is referenced by Observation and DiagnosticReport, ▪ Observation with Observation.partOf ImagingStudy

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			US Core indicates data interchange uses DiagnosticReport for: ▪ Cardiology (LP29708-2) ▪ Pathology (LP7839-6) ▪ Radiology (LP29684-5) Elements referenced with DiagnosticReport: • DiagnosticReport.status • DiagnosticReport.code (value set currently contains all of LOINC - the codes selected should represent discrete and narrative diagnostic observations and reports) • DiagnosticReport.encounter (healthcare event when ordered) • DiagnosticReport.effective[x] (Time of report or note) • DiagnosticReport.issued (When this version was made) • DiagnosticReport.performer (responsible diagnostic service) • DiagnosticReport.imagingStudy is a reference to FHIR ImagingStudy (but not referenced as MUST SUPPORT) • DiagnosticReport.result is a reference to Observation (but not referenced as MUST SUPPORT) Note: US Core does not include a *generic* Observation profile so the only way to reference an imaging study with a result is using DiagnosticReport. **Options for using QI-Core STU 4 to reference an imaging study** • **QI-Core ImagingStudy** (specifies an imaging study and its characteristics but not a specific instance of it) ▪ **QI-Core Observation** – QI-Core Observation.code (Codeable Concept) – MUST SUPPORT – Observation.value[x] (for result) – MUST SUPPORT – Observation.partOf (includes Reference to ImagingStudy) – Not listed as MUST SUPPORT ▪ **QI-Core DiagnosticReport-note** – QI-Core DiagnosticReport.imagingStudy (references QI-Core ImagingStudy) – MUST SUPPORT – QI-Core DiagnosticReport.result (references QI-Core Observation) - MUST SUPPORT

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			The User Group previously agreed to recommend use of **Observation** and include reference to **Imaging Study** (e.g., Observation.partOf ImagingStudy). ESAC suggested in the next update to QI Core, that it may help to indicate MUST SUPPORT for the **partOf** element to allow reference to an Imaging Study to indicate the source of the observation. **Discussion:** Yanyan Hu (TJC) recalls the conversation and asked ESAC to confirm whether the plan is to use Observation with or without result. ESAC confirmed Observation indicates a result is present. Imaging Study alone does not include an indication that there is a result. Yanyan asked if we will continue to follow CMS Blueprint terminology for the FHIR resource. ESAC suggested this question should be posed to the Governance Group. Specifically, the Blueprint provides guidance for which terminology to use for QDM datatypes and attributes because QDM does not have terminology bindings. However, FHIR (and therefore QI-Core) has specific terminology and value set bindings for many resources and elements. Therefore, the Blueprint may need to retire Table 17 (the terminology recommendations) after the transition to FHIR since FHIR specifies the bindings for interoperability. The Blueprint table is still followed for QDM since QDM is a conceptual data model that does not have value set bindings.. **Resolution/Next Steps:** The User Group did not recommend any changes to QDM at this time.
15 Minutes	QDM Errata – Section 2.6.5	Floyd Eisenberg (ESAC)	**Overview:** **Section 2.6.5 of QDM 5.5 provides an example of how to use the QDM entities to specify an Individual Actor is a Member of an Organization (existing content):** Define “Qualifying Encounters” [“Encounter, Performed”: “Inpatient”] Encounter where Encounter.participant is “Organization” define “Eye Exam Order” [“Intervention, Order”: “Diabetic Eye Exam”] ExamOrder where ExamOrder.requester is Practitioner and ExamOrder.requester.id in (Encounter.participant as Organization) define “Eye Exam Complete” [“Intervention, Performed”: “Diabetic Eye Exam”] EyeExam where EyeExam.performer is Practitioner and EyeExam.performer.id in Encounter.participant.organization

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			However, the conclusion from further testing is that CQL cannot connect the performer.id with the participant.organization with the current QDM structure. To do so requires a new attribute for the QDM entity Practitioner – *organization.id* with a cardinality of 0..*. This attribute would allow for a practition to be a member of none, one or multiple organizations. **QDM Entities – Current Content Recap** ▪ **Patient – information about an individual receiving healthcare services** – Identifier – id (instance identifier) ▪ **Care Partner – a person that is related to a patient, but who is not the direct target of care** – Identifier – id (instance identifier) – relationship ▪ **Practitioner – a person with a formal responsibility in the provisioning of healthcare or related services** – Identifier – id (instance identifier) – role (role this practitioner may perform [e.g., physician, nurse]) – specialty (specific specialty of the practitioner [e.g., anesthesia, cardiology, gastroenterology]) – qualification (coded representation of the certification, licenses, or training pertaining to the provision of care [e.g., MD, CNE, CHPN, ACNP, PA]) ▪ **Organization –a grouping of people or organizations with a common purpose** – Identifier – id (instance identifier) – type (kind of organization [e.g., hospital]) MD – medical doctor, CNE – certified nurse educator, CHPN – certified hospice and palliative nurse, ACNP – acute care nurse practitioner, PA – physician assistant **To enable such a reference (i.e., a practitioner is a member of an organization) for QDM 5.6 requires a new attribute for Practitioner:** ▪ **Practitioner – a person with a formal responsibility in the provisioning of healthcare or related services** – Identifier – id (instance identifier)

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			– role – specialty – qualification – **ADD** organization.id (cardinality 0..*) Alternatively, QDM could maintain its current structure, requiring the performer of different activities within an expression to be the same individual or the same organization and await the FHIR transition for this capability. In either case, a QDM Known Issue should indicate the fact that Section 2.6.5 is incorrect and will not work. Moreover, the Known Issue could indicate that limiting the performer of two actions to be the same individual has potential consequences in the measure results. Consider the following example: ["Physical Exam, Performed": "Blood Pressure"] BP and [Encounter, Performed": "Office Visit"] OfficeVisit where BP.*performer.id* = OfficeVisit.*participant.id* ▪ In this example, the expression expects the individual performing the blood pressure examination to be the same individual who is the primary participant for the encounter. ▪ Stated another way, To conclude TRUE, the same individual taking the BP MUST be the same as the primary participant for the OfficeVisit. ▪ This expression will conclude FALSE If the BP performer is a device or a nurse and the OfficeVisit participant is a physician. **Discussion:** ESAC noted this issue was raised on a Cooking with CQL session. The stakeholder asked how to indicate the performer of the activity is in the same organization. Joe Kunisch (Memorial Hermann) suggested significant challenges in connecting individuals to organizations. Currently, organizations are identified by tax id. His organization has employed physicians and private physicians. Private physicians do their own billing with their own tax id number; such data is not necessarily shared with the Memorial Herman system. The scenario would be difficult to implement. **Resolution/Next Steps:** Further discussion is needed. Stakeholders should consider whether this is worthwhile and feasible. Will include in the next QDM User Group to determine if there is any interest in adding the *organization.id* attribute to QDM 5.6 Practitioner entity. Based on discussion, ESAC will move

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			forward with a Known Issue for QDM 5.5 to avoid confusion with the existing section 2.6.5.
15 Minutes	HL7 FHIR Connectathon 25	Rob Samples (ESAC)	▪ HL7 FHIR Connectathon will be held VIRTUALLY between September 9-11, 2020. ▪ The CMS eCQM Standards Team will continue to participate in the Clinical Reasoning Track with a focus on Quality Measurement and Clinical Decision Support (CDS) Use Cases. ▪ The 2020-09 DaVinci Gaps in Care/Member Attribution Track will also continue testing the use of Data Exchange for Quality Measures (DEQM IG) for gaps in care and testing the use of the Member Attribution. **Clinical Reasoning Track Objectives** ▪ Continue testing Quality Measurement use cases. – Evaluate FHIR-based eCQMs written with CQL. – Test eCQM structure, packaging, and reference libraries from draft MAT on FHIR export packages. – Test and validate the use of the QI-Core model in CQL authoring. – Test supplemental data use cases for eCQMs. – Test continuous variable and stratified eCQMs. ▪ Test the use of FHIR resources in alignment with FHIR R4 Implementation Guides (IG). – QI-Core IG. – Quality Measure IG. – Data Exchange for Quality Measures (DEQM) IG. ▪ Test FHIR Clinical Guidelines example content (in coordination with the Care Planning and Public Health tracks). ▪ Test the new `order-select` hook using CDC Opioid Prescribing (in coordination with the CDS Hooks track). ▪ Conduct end-to-end testing: identify a gap, close gap and report measure, specifically Breast Cancer Screening--CMS 125v8 or v9 (in coordination with the DaVinci DEQM Gaps in Care track). ▪ Continue investigation of bulk import support. ▪ Test the ExecutableLibrary profile. ▪ Test the following CMS Measures for FHIR R4:

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Eligible Professional (EP)/Eligible Clinician (EC) Measures

2019 Reporting Measures	2020 Reporting Measures	2021 Reporting Measures	Other Measures for Consideration
▪ CMS130v7: Colorectal Cancer Screening ▪ CMS125v7: Breast Cancer Screening	▪ CMS165v8: Controlling High Blood Pressure ▪ CMS349v2: HIV Screening ▪ CMS124v8: Cervical Cancer Screening	▪ CMS74v10: Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists ▪ CMS124v9: Cervical Cancer Screening ▪ CMS149v9: Dementia: Cognitive Assessment ▪ CMS153v9: Chlamydia Screening for Women ▪ CMS347v4: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	▪ CMS127v9: Pneumococcal Vaccination Status for Older Adults ▪ CMS146v9:Appropriate Testing for Children with Pharyngitis ▪ CMS154v9: Appropriate Treatment for Children with Upper Respiratory Infection (URI) ▪ CMS155v9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents ▪ CMS159v9: Depression Remission at Twelve Months

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Eligible Hospital (EH)/Critical Access Hospital (CAH) Measures

2020 Reporting Measures	2021 Reporting Measures
▪ CMS104v8: Discharged on Antithrombotic Therapy ▪ CMS105v8: Discharged on Statin Medication ▪ CMS108v8: Venous Thromboembolism Prophylaxis ▪ CMS506v2: Safe use of opioids - concurrent prescribing (Pre rule for 2020 reporting)	▪ CMS111v9: Median Admit Decision Time to ED Departure Time for Admitted Patients ▪ CMS529v1: Hybrid Hospital-Wide Readmission

Clinical Reasoning Track Next Steps

- **Review the Clinical Reasoning Track page and orientation materials.**
- **Register for Connectathon.**
  - Early-bird rates: $150 for members and $250 for non-members
  - **After August 21st**: $200 for members and $300 for non-members
- **Complete Clinical Reasoning Track Survey by September 1st**
- **Attend weekly planning meetings through September 8th**
  - Visit the Track page for meeting details
- **Create a HARP Account by August 26th**
  - For participants that would like to create and package FHIR® measures but don't have a MAT on FHIR account
- **Questions?**
  - Email fhir@esacinc.com.

Gaps in Care Objectives

- The **2020-09 DaVinci Gaps in Care/Member Attribution** Track
- Continue testing the use Data Exchange for Quality Measures (DEQM IG) for gaps in care reporting use cases using FHIR-based eCQMs
- Testing the use of the Member Attribution for gaps in care

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			Gaps in Care Track Scenarios ▪ Test the use of the gaps in care profiles and the $care-gaps operation specified in the September 2020 DEQM (Gaps in Care) Ballot ▪ Test an end-to-end gaps in care reporting scenario from running an initial gaps in care report, submitting additional data to close identified open gaps, running the gaps in care report again to confirm that the gaps were closed, to reporting a summary measure report ▪ Test the use of the populationReference extension to associate a specific evaluatedResource in a measure report with a population type code (i.e., numerator, denominator) ▪ Test the use of the Da Vinci Risk Based Contracts Member Attribution (ATR) List IG for gaps in care **Gaps in Care Next Steps** ▪ Review the **2020-09 DaVinci Gaps in Care/Member Attribution** Track page and orientation materials ▪ Contact the track lead for any questions ▪ Register for Connectathon ▪ Early-bird rates: $150 for members and $250 for non-members ▪ **After August 21st**: $200 for members and $300 for non-members ▪ Attend the Da Vinci Gaps in Care weekly community call ▪ Thursday, 2pm ET (meeting details available at the Da Vinci Project Confluence site)
5 Minutes	General Discussion	Floyd Eisenberg (ESAC)	Attendees had no further questions or discussion topics.
5 Minutes	Next Meeting	Traci Psihas (ESAC)	**Agenda items for next QDM user group meeting** – Contact us at gdm@esacinc.com – Or start a discussion: gdm-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** – Since the major points of discussion require input from the upcoming HL7 Working Group Meeting (September 21-25), the planned September 16, 2020 will be cancelled. – Next QDM User Group meeting will be October 21, 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
N/A	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 Sys
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
X	Debbie McKay	Unknown
N/A	Deidre Sacra	McKesson
N/A	Doug Goldstein	Epic
N/A	Drew Keller	Unknown
X	Evelyn Cody	Unknown
X	Floyd Eisenberg	ESAC
N/A	Gary Rezik	QIP
N/A	Ganesh Shanmugam	Glenwood Systems
X	Gayathri Jayawardena	ESAC
X	Grace Glennon	Yale CORE
N/A	Howard Bregman	Epic
N/A	Huy	Unknown
N/A	Isbelia Briceno	Cerner

Attended	*Name*	*Organization*
N/A	L Dejesus	Informedika
X	Lisa Anderson	NCQA
N/A	Lizzie Charboneau	MITRE
X	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
N/A	Michael Ryan	Unknown
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
N/A	Paul Denning	MITRE
X	Peter Muir	ESAC
N/A	Rachel Buchanan	Oregon Urology
N/A	Rayna Scott	PCPI
N/A	R Swaineng	Swaineng Associates
N/A	Rebeccah Baer	NCQA
N/A	Rinku Master	Unknown
N/A	Rob McClure	MD Partners
X	Rob Samples	ESAC
N/A	Robin Holder	Unknown
N/A	Rose Almonte	MITRE
N/A	Ruth Gatiba	Battelle
N/A	Ryan Clark	NCQA
N/A	Ryan Guifoyle	Unknown
N/A	Samuel Benton	NCQA
N/A	Sarah Sims	My Patient Insight
N/A	Sethuraman Ramanan	Cognizant

Attended	*Name*	*Organization*
N/A	James Bradley	MITRE
X	Jamie Lehner	PCPI
N/A	Jana Malinowski	Cerner
N/A	Janet Wagner	Unknown
X	Jen Seeman	ESAC
X	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
X	Juliet Rubini	Mathematica
N/A	Justin Schirle	Epic
N/A	Jay Frails	Meditech
N/A	Katie Magoulick	CMS
N/A	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	Shanna Hartman	CMS
X	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
N/A	Yvette Apura	PCPI
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
N/A	N/A	N/A