

Quality Data Model (QDM) User Group Meeting | MINUTES

Meeting date | 5/18/2016 2:30 PM EDT | Meeting location | Webinar link:
<https://esacinc2.webex.com/esacinc2/j.php?MTID=m44a035b19cbc63ce3310c583e0354de8>

Attendees:

	Name	Organization
	Alex Lui	Epic
	Ashley McCrea	ESAC
	Anna Bentler	The Joint Commission
X	Anne Coultas	McKesson
	Balu Balasubramanyam	MITRE
X	Chris Markle	ESAC
	Chris Moesel	Mitre
	Cindy Lamb	Telligen
	Cynthia Barton	Lantana
	Flor Cheatham	NA
X	Floyd Eisenberg	ESAC
	Howard Bregman	Epic
	Jae Kim	ESAC
X	Jamie Jouza	PCPI
	Jean Fajen	Telligen
X	Joe Kunisch	Memorial Hermann
X	Juliet Rubini	Mathematica
	Justin Schirle	Epic
X	Kathy Lesh	Battelle
	Kendra Hanley	AMA
	Name	Organization

	Name	Organization
	Margaret Dobson	Zepf Center
X	Marilyn Parenzan	The Joint Commission
	Michelle Dardis	The Joint Commission
X	Michelle Hinterberg	MediSolv
	Nadia Ramey	ESAC
	Patty McKay	FMOAI
	Rose Almonte	NA
X	Rute Martins	The Joint Commission
	Stan Rankins	Telligen
	Syed Zeeshan	eDaptive Systems
X	Tammy Kuschel	McKesson
	Toni Wing	NA
	Yan Heras	ESAC
	Yanyan Hu	TJC
X	Sam Anderegg	NA
	Dalana Ostile	NA
	Julia Skapik	ONC
	Dave Wade	NA
X	Ruth Gatiba	NA
	Rukma Joshi	ESAC
	Name	Organization

	Name	Organization
X	<i>Khadija Mohamed</i>	<i>ESAC</i>
X	<i>Kimberly Smuk</i>	<i>PCPI</i>
	<i>Laura Pearlman</i>	<i>NA</i>
	<i>Leela</i>	<i>NA</i>
X	<i>Lisa Anderson</i>	<i>The Joint Commission</i>
	<i>Daisey</i>	<i>NA</i>
	<i>Jennifer Bonner</i>	<i>NA</i>
	<i>Kelly Cook</i>	<i>NA</i>
	<i>Paula</i>	<i>NA</i>
	<i>Shon Vick</i>	<i>ESAC</i>
	<i>Wendy Wise</i>	<i>NA</i>
X	<i>Marc Hadley</i>	<i>MITRE</i>
X	<i>Guy Ginton</i>	<i>ESAC</i>
	<i>Abby Rech</i>	<i>NA</i>
	<i>Brina Watson</i>	<i>NA</i>
X	<i>Mike</i>	<i>NA</i>

	Name	Organization
	<i>Zahid Butt</i>	<i>NA</i>
	<i>Rebecca Swain-Eng</i>	<i>NA</i>
	<i>Amanda Hashman</i>	<i>NA</i>
X	<i>Angela Flanagan</i>	<i>NA</i>
	<i>Anne Smith</i>	<i>NA</i>
	<i>Debbie Hall</i>	<i>NA</i>
	<i>Julie Koscuiszka</i>	<i>NA</i>
X	<i>Lynn Perrine</i>	<i>NA</i>
X	<i>Ryan Clark</i>	<i>NA</i>
	<i>Susan Wisnieski</i>	<i>NA</i>
X	<i>Vaspaan Patel</i>	<i>NA</i>
X	<i>Jenna Williams-Bader</i>	<i>NA</i>
	<i>J Frails</i>	<i>NA</i>
	<i>Ben Hamlin</i>	<i>NA</i>
	<i>Yvette Apura</i>	<i>NA</i>
	<i>NA</i>	<i>NA</i>

Time	Item	Presenter	Discussion/Options/Decisions
35 Minutes	Assessment & Functional Status Datatype	Floyd Eisenberg - ESAC	<p>1. Present previously determined definition:</p> <p>Assessment is a resource used to define specific observations that clinicians use to guide treatment of the patient. An assessment can be a single question, or observable entity with an expected response, an organized collection of questions intended to solicit information from patients, providers or other individuals, or a single observable entity that is part of such a collection of questions.</p>

Time	Item	Presenter	Discussion/Options/Decisions
35 Minutes (continued)	Assessment & Functional Status Datatype (continued)	Floyd Eisenberg - ESAC (continued)	<p>2. Review attributes:</p> <ol style="list-style-type: none"> a. Negation Rationale b. Result c. Start Datetime d. Stop Datetime e. Result options currently allow: <ol style="list-style-type: none"> 1. <i>is present</i> – returns whatever is in the result fields 2. <i>value set</i> – returns true only if the content of the field matches one of the codes in the value set provided 3. <i>numerical</i> – can specify a specific number (e.g., = 0) or a range (e.g., ≤ 5, or ≥ 1) 4. <i>New – time/date stamp</i> – REQUIRED BUT NOT CURRENTLY AVAILABLE in MAT – (HL7 templates can support a time / date stamp) <p>3. <i>Current Measures using Functional Status, Performed:</i></p> <ol style="list-style-type: none"> a. <i>CMS66v5</i> <p><i>Functional Status Assessment for Total Knee Replacement</i> <i>Domain: Patient and Family Engagement</i> <i>Percentage of patients 18 years of age and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported functional status assessments</i> "Functional Status, Performed: Functional Status Assessment for Knee Replacement" using "Functional Status Assessment for Knee Replacement Grouping Value Set</p> b. <i>CMS56v5</i> <p><i>Functional Status Assessment for Total Hip Replacement</i> <i>Domain: Patient and Family Engagement</i> <i>Percentage of patients 18 years of age and older with primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported functional status assessments</i> "Functional Status, Performed: Functional Status Assessment for Hip Replacement" using "Functional Status Assessment for Hip Replacement Grouping Value Set (2.16.840.1.113883.3.464.1003.118.12.1029)"</p>

Time	Item	Presenter	Discussion/Options/Decisions
Assessment & Functional Status Datatype (continued)	Floyd Eisenberg - ESAC (continued)		<p data-bbox="835 172 1020 199">c. CMS90v6</p> <p data-bbox="1075 211 1860 238"><i>Functional Status Assessments for Congestive Heart Failure</i></p> <p data-bbox="1075 248 1612 276"><i>Domain: Patient and Family Engagement</i></p> <p data-bbox="1075 285 1997 383"><i>Percentage of patients 65 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments</i></p> <p data-bbox="1075 393 1997 490">"Functional Status, Performed: Functional Status Assessment for Heart Failure" using "Functional Status Assessment for Heart Failure Grouping Value Set (2.16.840.1.113883.3.464.1003.118.12.1031)"</p> <p data-bbox="743 500 915 527">4. Proposal:</p> <ul style="list-style-type: none"> <li data-bbox="835 558 1997 623">a. Merge "Functional Status Assessment" with "Assessment" which also incorporates the previous "Risk Category/Assessment" <li data-bbox="835 651 1969 748">b. Assessment alone, without a context is inconsistent with other QDM modeling. Therefore, contexts such as "Performed," "Recommended" and "Ordered" should be considered. <p data-bbox="743 781 940 808">5. Discussion:</p> <ul style="list-style-type: none"> <li data-bbox="835 839 1997 1011">a. Merging Functional Status with Assessment is consistent with the initial intent, providing a broader description of Assessment and simplifying the QDM. The existing examples come from NCQA measures and "Assessment" will be sufficiently expressive for those measures especially since both Functional Status and Assessment use the same templates in QDM-based HQMF and QRDA. <li data-bbox="835 1040 1398 1068">b. The context of "performed" make sense <li data-bbox="835 1097 1997 1232">c. The context of "ordered" does not seem consistent with clinical workflow or process. A provider and patient may identify a target outcome for a care plan but generally there is no order for actually performing the assessments to determine the target outcome is achieved.

Time	Item	Presenter	Discussion/Options/Decisions
35 Minutes (continued)	Assessment & Functional Status Datatype (continued)	Floyd Eisenberg - ESAC (continued)	<p>d. The context of “recommended” led to significant discussion. Measure developers addressed the need to determine that a provider recommended a patient have a subsequent assessment at various points in the future. Vendors raised significant concerns that there is no standard workflow process to enter a structured recommendation. Without such a structured element, reporting that any QDM element is recommended will be complex and may require a check box that does not necessarily have inherent value in the patient’s record (i.e., the EHR will not have something upon which to take action).</p> <ol style="list-style-type: none"> 1. The group consensus was to retain two <i>contexts</i> for Assessment: <ol style="list-style-type: none"> a. Assessment, Performed b. Assessment, Recommended 2. The group further agreed that the QDM documentation include recommendation to carefully address feasibility in testing measures, specifically referencing any <i>recommended</i> elements. The additional language in QDM documentation will be important to assure measure developers carefully investigate the value and feasibility of requiring structured documentation of such elements.

Time	Item	Presenter	Discussion/Options/Decisions																																								
30 Minutes	Negation Rationale Update	Floyd Eisenberg - ESAC	<p>1. Review of existing QDM Datatypes that allow <i>negation rationale</i> attributes:</p> <table border="1" data-bbox="800 204 1982 873"> <tr> <td>1. Communication: From Patient to Provider</td> <td>21. Laboratory Test, Order</td> </tr> <tr> <td>2. Communication: From Provider to Patient</td> <td>22. Laboratory Test, Performed</td> </tr> <tr> <td>3. Communication: From Provider to Provider</td> <td>23. Laboratory Test, Recommended</td> </tr> <tr> <td>4. Device, Applied</td> <td>24. Medication, Administered</td> </tr> <tr> <td>5. Device, Order</td> <td>25. Medication, Discharge</td> </tr> <tr> <td>6. Device, Recommended</td> <td>26. Medication, Dispensed</td> </tr> <tr> <td>7. Diagnostic Study, Order</td> <td>27. Medication, Order</td> </tr> <tr> <td>8. Diagnostic Study, Performed</td> <td>28. Physical Exam, Order</td> </tr> <tr> <td>9. Diagnostic Study, Recommended</td> <td>29. Physical Exam, Performed</td> </tr> <tr> <td>10. Encounter, Order</td> <td>30. Physical Exam, Recommended</td> </tr> <tr> <td>11. Encounter, Performed</td> <td>31. Procedure, Order</td> </tr> <tr> <td>12. Encounter Recommended</td> <td>32. Procedure, Performed</td> </tr> <tr> <td>13. Functional Status, Order</td> <td>33. Procedure, Recommended</td> </tr> <tr> <td>14. Functional Status, Performed</td> <td>34. Risk Category/Assessment</td> </tr> <tr> <td>15. Functional Status, Recommended</td> <td>35. Substance, Administered</td> </tr> <tr> <td>16. Immunization, Administered</td> <td>36. Substance, Order</td> </tr> <tr> <td>17. Immunization, Order</td> <td>37. Substance, Recommended</td> </tr> <tr> <td>18. Intervention, Order</td> <td>38. Transfer From</td> </tr> <tr> <td>19. Intervention, Performed</td> <td>39. Transfer To</td> </tr> <tr> <td>20. Intervention, Recommended</td> <td></td> </tr> </table> <p>2. Issue: If Negation Rationale remains an attribute in the data model, CQL queries for actions that occurred require additional logic to indicate Negation Rationale is <i>null</i>. Examples:</p> <ol style="list-style-type: none"> The following returns all encounters, “negated” or not: [“Encounter, Performed”: “Inpatient”] The following returns encounters without a negation rationale (meaning they have not been “negated”): [“Encounter, Performed”: “Inpatient”] Encounter where Encounter.negationRationale is null The following returns encounters with a negation rationale (meaning they have been “negated”) [“Encounter, Performed”: “Inpatient”] Encounter where Encounter.negationRationale is not null The following returns encounters with a specific negation rationale: [“Encounter, Performed”: “Inpatient”] Encounter where Encounter.negationRationale in “Medical Reason” 	1. Communication: From Patient to Provider	21. Laboratory Test, Order	2. Communication: From Provider to Patient	22. Laboratory Test, Performed	3. Communication: From Provider to Provider	23. Laboratory Test, Recommended	4. Device, Applied	24. Medication, Administered	5. Device, Order	25. Medication, Discharge	6. Device, Recommended	26. Medication, Dispensed	7. Diagnostic Study, Order	27. Medication, Order	8. Diagnostic Study, Performed	28. Physical Exam, Order	9. Diagnostic Study, Recommended	29. Physical Exam, Performed	10. Encounter, Order	30. Physical Exam, Recommended	11. Encounter, Performed	31. Procedure, Order	12. Encounter Recommended	32. Procedure, Performed	13. Functional Status, Order	33. Procedure, Recommended	14. Functional Status, Performed	34. Risk Category/Assessment	15. Functional Status, Recommended	35. Substance, Administered	16. Immunization, Administered	36. Substance, Order	17. Immunization, Order	37. Substance, Recommended	18. Intervention, Order	38. Transfer From	19. Intervention, Performed	39. Transfer To	20. Intervention, Recommended	
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Time	Item	Presenter	Discussion/Options/Decisions
30 Minutes (continued)	Negation Rationale Update (continued)	Floyd Eisenberg – ESAC (continued)	<p>3. Options: Removing negation rationale as an attribute to QDM datatypes removes the requirement for the additional logic statements noted above.</p> <ul style="list-style-type: none"> a. Create 39 new datatypes – a <i>Not</i> version of each datatype allowing the attribute (and remove the attributes) – examples: <ul style="list-style-type: none"> 1. Procedure, performed 2. Procedure, <i>not</i> performed 3. Medication, administered 4. Medication, <i>not</i> administered 5. Device, applied 6. Device, <i>not</i> applied 7. Etc. 8. This option uses existing templates already identified in QDM-based HQMF and QRDA but creates 39 new datatypes to make the templates explicit. b. Create a new datatype “Not Done” with attributes of <ul style="list-style-type: none"> 1. Datatype 2. Reason not done 3. Examples: <ul style="list-style-type: none"> a. Not done (Procedure, performed: Cardiac surgery <value set>) (reason not done <value set>) b. Not done (Medication, administered: ACE Inhibitor Agents <value set>) (reason not done <value set>) c. Not done (Encounter, performed: Behavioral Health Visit <value set>) (reason not done <value set>) d. Etc. 4. The end result is a single new datatype that addresses only the existing datatypes that allow negation and allow sufficient expression to know the detail of what was <i>not done</i>, yet also allow the “reason not done.” 5. This option uses existing templates already identified in QDM-based HQMF and QRDA, but creates only 1 new datatype to make the templates explicit. c. No change – maintain attributes <i>as is</i> and consider tooling that might help with the additional logic statements required in CQL

Time	Item	Presenter	Discussion/Options/Decisions
30 Minutes (continued)	Negation Rationale Update (continued)	Floyd Eisenberg – ESAC (continued)	<p>4. Discussion: The UG reviewed the options listed with the following salient points:</p> <ul style="list-style-type: none"> a. Adding 39 datatypes explodes the data model, an option that was not preferred by data modelers through discussions at the HL7 meeting and elsewhere. Adding the 39 datatypes would also take QDM on a tangent inconsistent with existing and planned FHIR modeling. b. Adding a single “Not done” attribute may work and is consistent with some proposed efforts in HL7 for FHIR modeling with the Clinical Information Modeling Initiative (CIMI). However, the HL7 path is not yet solidified nor adopted. The option has a benefit of removing negation rationale as an attribute so the extra CQL logic is unnecessary. The option also requires analysis by the MAT and Bonnie groups to determine the work effort to make it work. c. Maintaining status quo, i.e., keeping negation rationale as an attribute does require additional logic statements. One UG member asked if the extra logic can be hidden from view in the human readable. The challenge with that option is that implementers and clinicians reading the human readable may try to interpret the data incorrectly. <p>5. Disposition: The UG agreed on a preference to explore option 2, i.e., a single “not done” QDM datatype. The ESAC team will explore the options and report back to the UG at the next meeting.</p>
20 Minutes	Timing Attributes – Intervals for QDM 5.0	Floyd Eisenberg - ESAC	<p>1. To recap prior discussions, CQL can be written more succinctly if start to stop times can be expressed as intervals (or “periods” as FHIR calls the timing attributes that address start and stop times). Therefore, the ESAC team initiated a review of all QDM datatypes and their related timing attributes. As suggested in prior calls, the team review how the QRDA and QDM-based HQMF modeled the start and stop times. ESAC presented a short summary of the progress with some examples.</p> <ul style="list-style-type: none"> a. The first issue identified was to determine how to manage author time as compared to a period of performance for the datatype. For example, Diagnosis currently addresses OnsetDateTime and AbatementDateTime. Thus a <i>period</i> of “effective time” should represent onset (effectiveTimeHigh) and abatement (effectiveTimeLow). And, that is how the datatype is modeled in QRDA. However, the UG has identified significant challenges in that onset date is not consistently captured even if the HER has a related field, and a “onset date” field is not available in all EHRs. Therefore, to address feasibility, it may be necessary to address author time.

Time	Item	Presenter	Discussion/Options/Decisions
20 Minutes (continued)	Timing Attributes – Intervals for QDM 5.0 (continued)	Floyd Eisenberg – ESAC (continued)	<p>b. Author time as a <i>period</i> may be challenging since the start of authoring is not necessarily captured in EHRs except as time spent signed on to the EHR for auditing. Hence, only the time signed, or completed, is actually captured for use in the measure reports. Therefore, author time might be better described as a single point in time as it is in QRDA and FHIR attributes.</p> <p>c. Naming conventions for QDM <i>periods</i> – The ESAC team considered two options:</p> <ol style="list-style-type: none"> 1. A generic naming such as “effective period” or just “period.” This option avoids the need for multiple terms to explain what should be specified using the underlying HL7 template. 2. A more specific description to more clearly define what is meant based on the datatype so the measure developer and consumer of the human readable understands the meaning without having to refer to QDM documentation each time. While the underlying coding in the templates should consistently provide the specific timing, additional description for the human readable may have benefit. <p>d. Some special cases may require additional consideration, e.g., how would a measure developer specify what is meant by a procedure’s start and stop time? A surgical procedure may have an incision and closure time; other procedures are not so definitive with respect to starting and stopping time.</p> <p>e. Disposition:</p> <ol style="list-style-type: none"> 3. Some UG members voiced a preference for more specific names for timing periods rather than a more generic description. 4. The ESAC team will continue to develop a straw man for final consideration by the UG. The proposal will include how to address existing timing attributes and it may also include some additional timing suggestions based on existing, more descriptive options in CDA and FHIR resources.

Time	Item	Presenter	Discussion/Options/Decisions
25 Minutes	Define Clinical Concepts Determined by Derivation	Floyd Eisenberg - ESAC	<ol style="list-style-type: none"> 1. Prior Jira tickets have suggested a need to describe specific data elements that may be derived from existing data. Gestational Age was presented as an example: <ol style="list-style-type: none"> a. ACOG Definition (https://www.acog.org/-/media/Departments/Patient-Safety-and-Quality-Improvement/201213IssuesandRationale-GestationalAgeTerm.pdf) <ol style="list-style-type: none"> 1. $ACOG = (280 \text{ days} - (EDD - \text{reference date})) / 7$ RATIONALE <ol style="list-style-type: none"> a. Separated out gestational age and estimated date of delivery b. Using weeks and days c. should no longer use fractions; always use weeks and days d. Gestational age is estimated from the best obstetrical EDD; are going backward from EDD instead of forward from LMP e. If no prenatal care, it is the pediatricians job to estimate gestational age EDD <ol style="list-style-type: none"> a. Last menstrual period (LMP) if confirmed by early ultrasound or no ultrasound performed, or Early ultrasound if no known LMP or the ultrasound is not consistent with LMP, or Known date of conception (eg. ART, IUI) 2. Gestational Age – American Academy of Pediatrics (http://pediatrics.aappublications.org/content/114/5/1362) Gestational age (completed weeks): time elapsed between the first day of the last menstrual period and the day of delivery. If pregnancy was achieved using assisted reproductive technology, gestational age is calculated by adding 2 weeks to the conceptional age. 2. Proposal: <ol style="list-style-type: none"> a. QDM Datatypes should allow expression of the component parts of clinical concepts. <ol style="list-style-type: none"> 1. CQL should allow logic expression of the relevant calculations (or QDM logic expression until CQL is adopted) 2. The completed logic represents a defined clause, or statement. 3. A library of <i>clauses</i> or <i>statements</i> can provide CQL/QDM statements that can be re-used with sufficient metadata and naming conventions to allow users to understand the intent and references 3. Discussion: One comment from the UG suggested that a library containing more than one clause to define a specific derived element could be confusing. While a single definition may be preferred, until there is consensus among clinical experts and/or harmonization of existing disparate definitions, measure developers may need to align with the specific experts guiding their individual measures. Harmonization is a governance issue which should be managed but it is not in the scope of the QDM or CQL.

Time	Item	Presenter	Discussion/Options/Decisions
10 Minutes	Additional Considerations for QDM definition	Floyd Eisenberg - ESAC	<p>1. Dataflow Attributes:</p> <ul style="list-style-type: none"> a. <i>Health Record Field</i>: The location within an electronic record where the data should be found. <ul style="list-style-type: none"> i. <i>Source</i>: The originator of the quality data element. The source may be an individual or a device. ii. <i>Recorder</i>: The individual or device that enters the data element into a health record field. The desired recorder also may be, but is not necessarily, the source of the data. iii. Discussion – These dataflow attributes have not been used due to the lack of such information in EHR data. The main issue is the lack of provenance related metadata. Some options: b. Health record field is redundant and may be overly prescriptive. The QDM datatype provides sufficient guidance to allow the EHR vendor or the local implementation site to determine the most appropriate “health record field(s)” that contain the relevant data. Some suggested there may be some future benefit to be prescriptive but not examples exist at present. c. Source may be ambiguous. The intent is to address the <i>informant</i>, which may be a better term. A clearer definition may also help. One example provided on the call was to explain the <i>informant</i> is the patient even though the recorder of the information may be a caregiver or clinician. d. Recorder seems well described. <ul style="list-style-type: none"> i. Disposition – Add greater description to the definition of “source” and consider changing the name to “informant.” Also add language to the “health record field” attribute to indicate it is generally not recommended as it is too prescriptive, noting that further use cases are needed to recommend appropriate usage.

Time	Item	Presenter	Discussion/Options/Decisions
10 Minutes (continued)	Additional Considerations for QDM definition (continued)	Floyd Eisenberg – ESAC (continued)	<p>2. Transfer from, Transfer to:</p> <ul style="list-style-type: none"> a. Should these be attributes of Encounter (source / disposition)? b. Review of CDA and FHIR resources identifies transfer from as the “source” attribute of Encounter, and transfer to as the “disposition” attribute of Encounter. Removing these two datatypes and adding “source” and “disposition” attributes for “Encounter, performed” and perhaps “Encounter, active” may allow clearer definition without the need for timing logic. This change may also allow more direct implementation by vendors and clinical sites. c. Discussion – One of the vendors on the call suggested that source and disposition is available directly from claims on the UB documentation and that there is no real additional benefit to capture such information clinically. Hence, removing the datatypes and adding Encounter attributes will require less work and improve implementability. To further investigate, the UG asked for a search through the MAT to determine the extent of use for “transfer to” and “transfer from” by all users, those creating measures for CMS and also those creating measures for other uses. Such analysis will help determine the right path to take. d. Disposition – Evaluate existing use of the datatypes in the MAT and report back to the UG. <p>3. Allergy/Intolerance, Adverse Reaction</p> <ul style="list-style-type: none"> a. Should these be datatypes with attributes of agent, reaction? <ul style="list-style-type: none"> i. Example: “Allergy: Type I Hypersensitivity Reaction (causative agent: Medication <value set>)? b. Discussion – The UG suggested aligning with recent HL7 discussions about management of allergy and intolerance in the Patient Care Workgroup. The recommendation originated with a review of current FHIR resources in which Allergy and Intolerance are modeled together, i.e. Allergy/Intolerance. Changing the focus by making Allergy/intolerance and Adverse Reaction as datatypes is a major change for QDM even though the templates in HL7 V3 and CDA (QDM-based HQMF and QRDA, respectively) are reusable. The option will take further analysis to determine the work effort to make such change. c. Disposition – Evaluate the work effort for such a change and review proposals for FHIR version 3.0 to assure alignment.

Time	Item	Presenter	Discussion/Options/Decisions
5 Minutes	Next Meeting	Floyd Eisenberg – ESAC	Agenda items for next QDM user group meeting <ul style="list-style-type: none"> – Contact us at qdm@esacinc.com – Or start a discussion: qdm-user-group-list@esacinc.com Next user group meeting <ul style="list-style-type: none"> – June 15th, 2:30pm – 4:30pm EST

Action item	Assignee
None	None

