The Office of the National Coordinator for Health Information Technology

Meeting Notes

U.S. CORE DATA FOR INTEROPERABILITY TASK FORCE 2021

February 16, 2021, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Steven Lane, co-chair, welcomed members to the U.S. Core Data for Interoperability Task Force 2021 (USCDI TF) Virtual meeting. He announced that **Terry O'Malley,** TF co-chair, would be stepping down. The TF discussed the use and posting of past meeting notes, and **Steven** presented a brief review of the revised USCDI TF charges. TF members finished submitting comments on Task 1a, and Steven presented Task 1b of Charge 1. A robust discussion was held, and TF members submitted feedback. **Steven** reviewed the TF schedule and plans for the next meeting. There were no public comments submitted by phone. There were several comments submitted via the chat in Adobe Connect.

AGENDA

10:30 a.m.	Call to Order/Roll Call
10:40 a.m.	Past Meeting Notes
10:50 a.m.	Task Force Charges
10:55 a.m.	USCDI TF Recommendations Document
11:00 a.m.	Tasks 1a and 1b
11:50 a.m.	TF Schedule/Next Meeting
11:55 a.m.	Public Comment
12:00 p.m.	Adjourn

CALL TO ORDER/ ROLL CALL

Michael Berry, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the February 16, 2021, meeting of the USCDI TF to order at 10:30 a.m. ET. **Steven Lane** introduced a new TF member, **Grace Cordovano**, Ph.D., and she explained that she is a board-certified patient advocate specializing in the field of oncology. As the founder of Enlightening Results, she helps patients navigate their diagnosis, their health information, and the healthcare system. Also, **Steven** explained that **Terry O'Malley** would not be able to continue on as the TF co-chair due to a personal conflict. A new co-chair of the TF will be named from the existing membership shortly.

ROLL CALL

Steven Lane, Sutter Health, Co-Chair
Ricky Bloomfield, Apple
Hans Buitendijk, Cerner
Grace Cordovano, Enlightening Results
Leslie Kelly Hall, Engaging Patient Strategy
Jim Jirjis, HCA Healthcare
Ken Kawamoto, University of Utah Health
Clem McDonald, National Library of Medicine
Mark Savage, University of California, San Francisco's Center for Digital Health Innovation
Michelle Schreiber, Centers for Medicare and Medicaid Services (CMS)
Sasha TerMaat, Epic
Sheryl Turney, Anthem, Inc.
Daniel Vreeman, RTI International
Denise Webb, Indiana Hemophilia and Thrombosis Center

MEMBERS NOT IN ATTENDANCE

Les Lenert, Medical University of South Carolina
Aaron Miri, University of Texas at Austin, Dell Medical School and UT Health Austin
Brett Oliver, Baptist Health
Andrew Truscott, Accenture

PAST MEETING NOTES

Steven Lane discussed the plan to complete three rounds of reviews on the USCDI TF meeting notes before posting them to the website. No formal approval process will be held, but the notes will be made available online prior to the next meeting to allow TF members to access and work from them. The notes from the first USCDI TF meeting held on February 2, 2021, are available on the USCDI TF's website at: https://www.healthit.gov/hitac/events/us-core-data-interoperability-task-force-19

TASK FORCE CHARGES

Steven Lane discussed the process used by the USCDI to encourage and gather comments on Version 2 of the USCDI and invited those who previously provided comments on Version 2 to add their comments to the USCDI website in order to properly enter them into the public record. **Dan Vreeman** suggested that adding comments to a specific data element or class is easier to review than the submission of blanket comments on the main page.

Steven reviewed the USCDI TF's overarching and specific charges, which were included on slide #3 in the presentation. The TF has revised the charges and completed work on Task 1a of Charge 1. Today, the TF will focus on Task 1b of Charge 1. **Steven** summarized feedback received on Version 2: some feel that too few items have been included, while others are pleased with the amount because the industry and vendors are more focused on COVID-19 relief efforts than upgrades at this time.

USCDI TF RECOMMENDATIONS DOCUMENT

Steven Lane explained that USCDI TF members have been given access to a collaborative Google document to facilitate co-working and record-keeping in between meetings. Anyone who does not have access to the document should email onc-hitac@accelsolutionsllc.com with their request. The plan is that the co-chairs and the ONC team will add information to the Google document, and TF members will be able to submit comments.

TASKS 1A AND 1B

Task 1a

Steven Lane discussed the depiction, which was included on slide #5 in the presentation, of changes to Version 1 proposed for inclusion in Version 2. **Steven** explained that at the previous meeting, USCDI TF members discussed some of these changes, including the reclassification of some of the data elements and classes under the Clinical Notes data class to the new data classes of Diagnostic Imaging and Laboratory. At the previous meeting, TF members had a lively discussion about the potential for redundancy and the challenges of moving these items. **Steven** encouraged TF members to submit further feedback, which included:

Discussion:

- **Dan Vreeman** summarized his previous comments:
  - The Laboratory Report Narrative data element requires clarification or might be redundant. He questioned how it relates to lab values.
  - The language for the Pathology Report Narrative data element should be revised to minimize confusion around the word "narrative." Pathology reports can vary in the amount of narrative presented, so the use of the word "narrative" might confuse people.
  - **Steven Lane** responded that data fields are needed to capture both quantitative data and narrative elements and discussed some might be confused by what is being requested within these elements.

  - **Al Taylor** explained that each of the three data elements could be part of the diagnostic imaging report or the lab report, which already contain narrative elements. ONC and the USCDI did not want to define the structure or contents of a lab report for diagnostic imaging, so the intent was to capture and then be able to exchange the narrative elements within clinical notes.
- **Clem McDonald** commented that this reclassification could be disastrously confusing. Lab reports are structured, but the reclassification could cause structured data to appear as text. Also, he worried that if there appears to be only a single code choice for the lab narrative, lab charts could be sent out as one large piece of text, thus destroying the past 15 years of work on structured lab reports. He discussed differences in the narrative/structure present in radiology and imaging and related challenges. He felt that these changes must be completely rethought.
  - **Steven Lane** suggested that these changes could remain if they are clarified in Version 2.
  - **Clem** disagreed, stating that giving a single LOINC code suggests that the item will be sent as a single unit and fails to indicate that both/either narrative and/or structured information will be sent.
  - **Al Taylor** thanked **Clem** for his comments and explained that the need for a separate, complete diagnostic imaging report (either unstructured or a combo) remains.
  - **Clem** suggested that work could be done through the comment process to improve the definitions for the narrative and lab report data elements.
- **Grace Cordovano** suggested that real-world examples to demonstrate the usefulness of the data classes and elements proposed for Version 2 would be helpful. She asked if synthetic data could be used to create a demonstration version of a “narrative” while also noting that she has seen the terms “impression” or “findings” used instead of “narrative.”
- **Hans Buitendijk** cautioned against separating “narrative” from the rest of the report and encouraged the use of the narrative within the report. Rather, the element should be clarified to call out the elements of a well-structured report, which would include narrative impressions, structure, and encoding.
- **Ricky Bloomfield** suggested that this level of granularity would typically occur during the creation of the implementation guide process. He asked if the USCDI TF’s guidance to ONC should be this detailed and where it should be included, or if the TF should share it with HL7 for use in an implementation guidance (US Core, C-CDA, v2).
- **Dan Vreeman** voiced his agreement with **Hans’** and **Clem’s** comments and emphasizes that they need to be rewritten to indicate that a single code cannot be used across all diagnostic imaging reports, narratives, or lab reports. Coding should be precise.
- **Leslie Kelly Hall** commented that the USCDI TF should not bypass the process already set up to vet and create new standards, even though many commenters find this change confusing. She warned the TF about the consequences of separating the context from the narrative.
- **Steven Lane** suggested creating draft language for the USCDI TF’s report to the HITAC to capture the opinions shared by TF members and asked if **Hans, Ricky,** or others would be willing to contribute. This paragraph will be added to the TF’s collaborative Google document.
  - TF members discussed how best to continue working in a collaborative manner.

Task 1b

Steven asked members to comment on the new data classes and elements proposed for the draft USCDI v2, including applicable standards.

Discussion:

- **Dan Vreeman** voiced his concern about the redundancy/overlap between the two data elements under the new Care Team Members data class, Provider Name and Provider Identifier. They have been labeled with "provider," which has regulatory and other implications. He suggested that they change them to Care Team Member Name and Care Team Member Identifier. The Identifier should be marked as "must support" but not required.
- **Grace Cordovano** discussed how medical models for care teams vary and suggested that **Dan's** comments do not take this into account. She emphasized the need for broader definitions for these elements, which may include information about changes in the care team during a patient's treatment journey and if care team members are granted power of attorney.
  - **Clem McDonald** discussed how people who bill to Medicare and others beyond the typical definition of "a provider" have been granted a national provider identifier (NPI).
  - **Steven Lane** encouraged all USCDI TF members to examine the website for additional details that have been suggested for the Care Team Members data class. He explained that there is an opportunity to clarify the details related to the data class but added that there are specific suggestions listed for "identifier." However, because Version 2 does not suggest the use of a specific identifier, there could be confusion at the system level.
  - **Al Taylor,** who was the submitter of these data elements for Version 2, explained that he added the data elements to fill existing gaps in Version 1. These data elements were already required by other certification criteria, including CMS, but they did not have a place in the USCDI yet. He agreed with **Grace's** comment that the suggested elements are medical model-centric, which is the original intended use case but also agreed with **Dan's** suggestion that the USCDI TF could recommend additional/different data elements. He explained that the Provider elements were placed in the Care Team data class because they are part of the care team; this was meant to avoid duplication.
  - **Steven** echoed **Al's** suggestion to bring Care Team Member Role into Version 2.
- **Denise Webb** stated that the public/patients are confused by the role of the USCDI and what it means when data elements are included in it. She discussed how the USCDI applies to vendors and is used by them when products are part of the certification program. She voiced her agreement with **Al** and **Steven's** suggestions.
- **Michelle Schreiber** suggested that the type of provider ID and the specialty/team should be specified to avoid confusion. She discussed the potential need for an organization/facility ID.
  - **Steven Lane** asked **Al** to provide clarification on the provider identifier and what is required to be provided for it.
  - **Al Taylor** explained the work that went into Version 2. The NPI is the identifier for the medical model provider, but other types of identifiers (DEA, etc.) were included to allow for the collection of a broader range of data and to cover a variety of care situations/providers. He suggested that the context is inherent to the particular kind of identifier used but asked for feedback on whether more specificity is needed.
  - **Steven** told **Al** that he sent an email request that they call out applicable standards for the provider role. Boundaries must be defined if the TF plans to suggest the inclusion of care team member roles.
  - **Al** responded that he would reshare the link to information about the NPI from the HL7 identifier value set.

Steven paused the meeting to allow **Terry O'Malley,** USCDI TF co-chair, to say a few words. **Terry** announced that he would be stepping down from the TF. He thanked **Steven** and everyone else for their efforts and stated that their work will shape interoperability for years to come. He thanked **Al Taylor** for supporting the ONDEC and SVAP processes. **Steven** thanked **Terry** and, on behalf of other TF members, expressed his gratitude for his years of service, including co-chairing previous iterations of the TF.

Discussion:

- **Steven Lane** summarized the comments submitted about the Care Team Members data class, which included: capturing the identifier, adding a supplementary field to specify the identifier type, and adding role to the provider/care team member. Steven asked Hans to speak as a developer about the time frame/constraints of adding additional data elements to an EHR.
  - **Hans Buitendijk** raised questions around the purpose of adding "Provider Identifier" or other specifying identifier types to the USCDI when they have already been required and defined by other standards, like FHIR (Fast Healthcare Interoperability Resources), C-CDA (the HL7 Consolidated Clinical Document Architecture), and US Core. Is the USCDI trying to lead or reflect the existing standards? How does the USCDI reference existing certified items from the standards?
  - **Steven** responded that the USCDI is meant to contain elements that are well-established in the standards that vendors have been shown to support. USCDI raises the floor of use.
  - **Al Taylor** voiced his agreement that the USCDI reflects the standards but is not wedded to the evolution of any specific one. He explained that programs that do not use certified technology are using USCDI as a reference, so it is meant to be modest. The USCDI is not meant to solve every specific use case.
  - **Hans** thanked him for his response and highlighted the idea that the USCDI purposely does not include elements from other standards if they might pose too large of a step forward for programs that do not use certified technology.
- **Clem McDonald** suggested including a code and a code system under the identifier as a way to leave this element open-ended but to capture all necessary information.
  - **Steven** responded that the Provider ID Type has not been called out as a separate data element and asked **Al** if it has been subsumed by Provider ID or if it is a missing element.
  - **Clem** responded that it is usually considered part of coding system ID in the standards systems, and the version being used is also important.
  - **Al Taylor** stated that the identifier type is produced by the code system and that this could be examined. He questioned if the USCDI should be tasked with solving this issue.
  - **Clem** responded that it is buried in the data type, so it depends on how the data type is coded in the system. He briefly discussed a variety of solutions.
- **Steven Lane** summarized suggestions for the Care Team Members data class, which included: moving the Care Team Member Role from Level 2 up to the draft Version 2 and clarifying that the Provider ID would also entail the coding system and version.
  - **Hans Buitendijk** suggested that the coding system/version would require some refining and noted that the concepts might not be separate.
- **Sasha TerMaat** described an industry/system developer perspective on Version 2 and stated that because the v2 list includes data elements that systems already support, it is reasonable to expect a continuous implementation of v2 on top of v1. When items lack clarity, it can limit the development/implementation process.
  - **Steven** thanked her and invited TF members to add clarifying comments at the individual data element level.
- **Steven** discussed the Encounter Information data class and invited TF members to contribute. He echoed **Sasha's** comment that this class aligns with quality reporting issues.
- **Michelle Schreiber** discussed her support for the data elements listed under Encounter Information and suggested adding other elements that are used in quality measures, including Encounter Disposition, Encounter Location, and Associated Time Period. This kind of information is more complicated than it seems.

  - **Steven** responded that several of these items were proposed but were assigned to Level 2, while Time Period was assigned to the Comment level. A discussion of whether to pull them up to draft v2 will be held.
- **Dan Vreeman** spoke in favor of including all of the listed data elements under the data class and suggested clarifying the definition and intent of Encounter Time.
- **Clem McDonald** suggested looking at what is well-establish and already in use in the standards to inform the USCDI TF's work and suggested that they not be stingy with items for inclusion in v2. He agreed that Encounter Time needs to be better defined to indicate the date or date range.
  - **Steven** commented that Encounter Time had a public comment from someone named Janice, who was not on the current call. He summarized comments that Encounter Location and Encounter Disposition.
  - **Sasha TerMaat** asked if these inclusions would make sense in all contexts (like ambulatory services), and **Steven** agreed with her. **Sasha** asked the TF to come to a conclusion on what was meant by each proposed data class or element before attempting to assess the difficulty of including them in v2. She stated that they have varying levels of implication, depending on the domain.
- **Hans Buitendijk** stated that the next version of US Core includes Disposition under Hospitalization, not Encounter Information. Also, he commented that, though many include this concept, not all systems/settings use Encounter Information, so its inclusion could impact how some systems implement updates.
- **Steven** discussed comments TF members made in the chat in Adobe that supported Hans' comments that "Encounter" has a wide range of meanings outside of a hospital setting. However, he summarized that TF members seem to agree on the importance of the inclusion of these elements in the USCDI.

Michael Berry opened the meeting up for public comment:

PUBLIC COMMENT

There were no public comments received by telephone.

Questions and Comments Received via Adobe Connect

Mike Berry: Good morning, everyone! Thanks for joining. We will get started shortly.

Grace Cordovano, PhD, BCPA: Good morning! I'm here but having trouble with video and apparently audio.

Mark Savage: Good morning, Grace!

Ricky Bloomfield: Ricky is here.

Ricky Bloomfield: @Grace, audio only works by phone.

Grace Cordovano, PhD, BCPA: Thanks Ricky! Trying to connect

Jim Jirjis: Jim Jirjis here

Grace Cordovano, PhD, BCPA: Been on hold

Clem McDonald: I am here, Clem.

Zoe Barber: Good morning everyone, Zoe Barber here from NYeC

Mike Berry: Clem and Jim - attendance noted. Thanks!

Jim Jirjis: Not sure that I got the access and sent my email

Jim Jirjis: what email do i sent the email to?

Sheryl Turney: Would you resend to the TF the link to the document. I could not find it.

Katherine Campanale: onc-hitac@accelsolutionsllc.com

Sheryl Turney: found it with my access email.

Leslie Kelly Hall: I agree @Clem

Grace Cordovano, PhD, BCPA: I have comments as well

Ricky Bloomfield: USCDI is concerned with the datat *[sic]* type, but not the implementation guidance, right? Would we need to share implementation guidance with US Core/HL7?

Leslie Kelly Hall: This will add cost and confusion and imagin *[sic]* a patient app trying to figure this out.

Leslie Kelly Hall: shouldnt *[sic]* we change the standards in the standards org process and not here?

Leslie Kelly Hall: agreed @Ricky

Ken Kawamoto: Sorry I have to join another meeting. Have a great week everyone.

Denise Webb: I would add that the SNF community is not clear on how the USCDI applies to them since they often don't use certified health IT yet is subject to the infomration *[sic]* blocking provisions

Hans Buitendijk: @Ricky: Agreed that the standards/implementation guide should have the specific defintiions *[sic]* on how to express USCDI data. USCDI should have enough indication though on what is to be addressed. So if the goal is to improve on reports with better use of structure, narrative, and encoding/quantitative/qualtitative *[sic]* data, then the report data element should describe that rather than having a separate data concept. Unless the intent is to truly suggest two separate concepts.

Grace Cordovano, PhD, BCPA: I'm concerned about surgical reports not called out specifically. It was my understanding from last meeting that they will be lumped under Procedures, but clinically speaking, procedures are not surgical.

Leslie Kelly Hall: We are talking about 30 years of use in lab and pathology this is a culture and tech change

Ricky Bloomfield: @Hans, yes totally agree. Sounds like you already have a start on the requested paragraph!

Shelly Spiro: Thanks for mentioning the comments I made from Pharmacy HIT Collaborative (Shelly Spiro) related to payor/coverage codes

Hans Buitendijk: Second @Dan's suggestion that provider name is actually captured already in Care Team standards/implementation guidance where each care team member has a name, whether provider, patient, or organization.

Sasha TerMaat: I agree with Dan and Hans.

Grace Cordovano, PhD, BCPA: Agree with @Leslie; needs to include patient's primary carepartners *[sic]*, advocates, executor of the estate, personal representative

Hans Buitendijk: Not every care team member has an NPI, so identifier should not be limited to NPI, nor be required, or practical to obtain for everybody.

Mark Savage: Dan's comment is spot on. But perhaps we could also hear from ONC about why limited to providers only?

Daniel Vreeman: Right, my proposal is that we should use "Care Team Member Name" and "Care Team Member Identifier" as the two labels for the data element. And that would cover the very broad range of possible care team members. https://www.healthit.gov/isa/uscdi-data/care-team-members-0#uscdi-draft-v2

Hans Buitendijk: In the upcoming US Core version, RelatedPerson *[sic]* is targeted to be included as well

Hans Buitendijk: In the current version, .role is already a Must Support as well and not targeted to be dropped.

Leslie Kelly Hall: agree steven on ID this could be a start for the patients that have been identity proofed..

Leslie Kelly Hall: @Hans related person sounds inteteresting *[sic]*. can you send link

Clem McDonald: DEA is only avaible *[sic]* to those who prescribe narcotics and the like. And it now costs $880 per renewal. If is very restricted and very medical mdoel *[sic]* centric. Would not perfer *[sic]* it over NPI

Grace Cordovano, PhD, BCPA: In chronic illness, life-altering, life-limiting situations, there could be a number of providers that do see the patient but perhaps only 3 to 4 times a year. In these care circumstances, primary carepartners *[sic]* often "see" the same patient, their loved one, 365 days a year. Critical to capture this.

Clem McDonald: Agree with Al on the last poing *[sic]*

Daniel Vreeman: Typically, with ID/Code data types, the content is represented in a multi-part format (ID, CodeSystem) so you'd know whether the identifier was a DEA #, NPI# or something else.

Leslie Kelly Hall: agree steven on level 2 moving to V2

Clem McDonald: This harkens back to perhaps another silde *[sic]*.

Daniel Vreeman: +1 on adding Care Team Member Role as another data element

Leslie Kelly Hall: @Denise, this is used for the openapi *[sic]* for patient apps as well which is not certified

Denise Webb: The other issue around adding data elements such as care team identifier or provider identified, there needs to be clarity for the developers on exactly what their product needs to support in terms of identifier types .

Leslie Kelly Hall: even level 2 documents location but not organization

Leslie Kelly Hall: an ID as a requirement should be considered for any care team member

Grace Cordovano, PhD, BCPA: Does anyone have a reference on how a patient could get an NPI? I thought this was only for HIPAA covered entities, individuals or organizations?

Ricky Bloomfield: Great working with you and I wish you the very best!

Daniel Vreeman: Thanks for your leadership Terry! We'll miss working with you on this!

Leslie Kelly Hall: @ grace there are efforts in ONC and PEW and RTI to look at patient id that is digital and secure. this could expand to any care team member.

Grace Cordovano, PhD, BCPA: Best wishes to you Terry! Thank you for all your work in this space!

Mark Savage: Thank you, Terry, for the leadership and expertise!

Grace Cordovano, PhD, BCPA: @Leslie, thank you for clarifying

Michelle Schreiber: Thank you Terry for your leadership in this and in many other aspects of care. Best wishes.

Zoe Barber: As an HIE implementing patient event notifications for the majority of hospitals in NYS, the provider name and identifier are not sufficient for routing notifications to that provider. Our HIEs need to check 3-4 external directories in order to track down the appropriate endpoint , and often that's not enough.

Leslie Kelly Hall: I may be wrong @al is this the only place (care team) where provider information is noted?

Clem McDonald: units of measure are essential to the interpretation of every numberic *[sic]* Code. TIn *[sic]* USCID ,they are now required to be UCUM standard for vital signs. And UCUM is required fo *[sic]* reporting units for quantiative *[sic]* values in ONC supported Cstandareds *[sic]* including HL7 FHIR , HL7 CCDA and in DICOMnd *[sic]* DICOM . I UCUM was brrequired *[sic]* for laboratory tests briefly in an earlier vesion *[sic]* on USCID but now it h has disappeared. THAT is a problem for automatic use of laboratory data

Denise Webb: My understanding of USCDI is that it expands the common clinical data set that for certification criteria requiring the ability to access and exchange these data elements electronically

Denise Webb: I also understand that their are patient apps that are not certified that are using the USCDI and would be expecting they could access these elements on behalf of a patient from the EMR

Denise Webb: *there are

Leslie Kelly Hall: If as Hans states many of these things are already in place, can we just use the HL7 descriptions in the provider definitions?

Hans Buitendijk: What I'm hearing is that it informs the scope of not only what needs to be certified (using C-CDA and US Core), but also other initiatives, including information blocking in general scope,

that would not necessarily involve those standards. So while we could suggest that USCDI be harmonized with C-CDA/US Core "fully", that may creaate *[sic]* challenges for others.

Leslie Kelly Hall: @hans is it harder to piecemeal the development to USCDI or by class of data like provider?

Mike Berry: We will be opening the line for public comment about 11:55. To make a comment please call: 1-877-407-7192(once connected, press "*1" to speak)

Al Taylor, ONC: @Leslie yes. Provider info is in Care Team members, but those data elements could be used for other purposes, such as lending attributes to "procedures"

Al Taylor, ONC: Level 2 encounter data elements: https://www.healthit.gov/isa/uscdi-data/encounter-information

Leslie Kelly Hall: agreed @clem, all encounter types should include, telehealth for example

Shelly Spiro: For the Pharmacist eCare Plan we needed to address the encounter as face to face, telephonic and video (e.g. telehealth)

Grace Cordovano, PhD, BCPA: Curious regarding Encounter Time, from the patient perspective, will encounter time begin when, for example, a patient arrives for their 9 a.m. appointment, but is then seen at 2 p.m.? Will this enable documenting when patients arrive at the ER and spend XX number of hours waiting for a bed?

Leslie Kelly Hall: @grace encounter time is based upon the billable time for that event.

Daniel Vreeman: Re Encounters, should also keep in mind that in API world, you can call for the Encounter info while it's still in progress, so the end time or discharge disposition may not be available. So the notion of send it if you've got it (but not mandatory in every specific instance) applies here too.

Leslie Kelly Hall: Agree with the stingy comment and that should be overriding all of this

Denise Webb: @Steve, this is true for SNF's too with regard to what they collect for encounter diagnosis and encounter type

Mark Savage: In addition to stingy, the critical need across care settings that demands we should not be stingy.

Grace Cordovano, PhD, BCPA: :)

Hans Buitendijk: Can you coordinate coordinates to where we can collaborate?

TF SCHEDULE/NEXT MEETING

Steven Lane encouraged USCDI TF members to be prepared to discuss the Encounter Information topic in depth at the next TF meeting. He reviewed the meeting schedule for upcoming meetings over the next month, which was:

- February 23, 2021, 10:30 a.m. – 12:00 p.m. ET
- March 2, 2021, 10:30 a.m. – 12:00 p.m. ET
- March 9, 2021, 10:30 a.m. – 12:00 p.m. ET
- March 16, 2021, 10:30 a.m. – 12:00 p.m. ET

ADJOURN

Steven Lane thanked everyone and encouraged them to ensure they have access to both the USCDI website and the collaborative Google drive document.

The meeting was adjourned at 11:59 a.m. ET.