## HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) U.S. CORE DATA FOR INTEROPERABILITY TASK FORCE MEETING

March 23, 2021, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL

# Speakers

| Name | Organization | Role |
|------|--------------|------|
| **Leslie Kelly Hall** | **Engaging Patient Strategy** | **Co-Chair** |
| **Steven Lane** | **Sutter Health** | **Co-Chair** |
| Ricky Bloomfield | Apple | Member |
| Hans Buitendijk | Cerner | Member |
| Grace Cordovano | Enlightening Results | Member |
| Jim Jirjis | HCA Healthcare | Member |
| Ken Kawamoto | University of Utah Health | Member |
| John Kilbourne | Department of Veterans Health Affairs | Member |
| Leslie Lenert | Medical University of South Carolina | Member |
| Clement McDonald | National Library of Medicine | Member |
| Aaron Miri | The University of Texas at Austin, Dell Medical School and UT Health Austin | Member |
| Brett Oliver | Baptist Health | Member |
| Mark Savage | University of California, San Francisco's Center for Digital Health Innovation | Member |
| Michelle Schreiber | Centers for Medicare and Medicaid Services | Member |
| Sasha TerMaat | Epic | Member |
| Andrew Truscott | Accenture | Member |
| Sheryl Turney | Anthem, Inc. | Member |
| Daniel Vreeman | RTI International | Member |
| Denise Webb | Indiana Hemophilia and Thrombosis Center | Member |
| Michael Berry | Office of the National Coordinator for Health Information Technology | Designated Federal Officer |
| Al Taylor | Office of the National Coordinator for Health Information Technology | Staff Lead |

## Call to Order/Roll Call (00:00:00)

**Operator**
All lines are now bridged.

**Michael Berry**
Great.  Good morning, everyone. I'm Mike Berry with ONC. And I'd like to welcome you back to the USCDI task force. And we're really excited to have you join us today. And we have lots to cover so we'll jump right in. I am going to start with roll call to kick us off. And I'll start with our co-chairs. Steven Lane.

**Steven Lane**
Good morning.

**Michael Berry**
Leslie Kelly Hall.

**Leslie Kelly Hall**
Good morning.

**Michael Berry**
Ricky Bloomfield.

**Ricky Bloomfield**
Good morning. I'm here.

**Michael Berry**
Hans Buitendijk.

**Hans Buitendijk**
Good morning.

**Michael Berry**
Grace Cordovano.

**Grace Cordovano**
Good morning.

**Michael Berry**
Jim Jirjis. Ken Kawamoto.

**Ken Kawamoto**
Good morning.

**Michael Berry**
John Kilbourne.

**John Kilbourne**
Good morning.

**Michael Berry**
Les Lenert. Clem McDonald. Aaron Miri. Brett Oliver. Mark Savage.

**Mark Savage**
Good morning.

**Michael Berry**
Michelle Schreiber.

**Michelle Schreiber**
Good morning.

**Michael Berry**
Sasha TerMaat. Andy Truscott. Sheryl Turney.

**Sheryl Turney**
Good morning.

**Michael Berry**
Dan Vreeman.

**Daniel Vreeman**
Good morning.

**Michael Berry**
And Denise Webb.

**Denise Webb**
Good morning.

**Michael Berry**
Good morning, everybody. And if we missed your name, I'll keep track as you dial in and note your attendance. So, with that, I will turn it over to Steven and Leslie.

## Past Meeting Notes (00:01:37)

**Steven Lane**
Thank you so much, Mike. So, thank you all for showing up this morning. We really appreciate it. We're definitely into the home stretch of our first phase of work in anticipation of our recommendations to the HITAC that are due early next month. We have been continuing to complete meeting notes and post those to the public website. Those are available for everyone's review. And I hope people take the time to look at

them. And if you have any questions, this would be a great time to raise those. Hearing none, just know that those are there. We really have a lot to get through. And I wanted to kind of orient us here.

## Tasks 1b and 1c (00:02:30)

### Steven Lane

Why don't you go to the next slide here? Thank you. Sorry. We went through the roster as part of the roll call. Let's get to the following slide. And we have done a lot of work, again, on the task force charges. I think there were a couple of additional comments entered. I think, Grace – or no, it was Michelle, I think, had a new 1A that we want to look at and then, we're going to jump right back into the 1C, which is going to really be our focus here.

But I want to remind everyone that we have an opportunity and, I think, a responsibility to put together a set of recommendations to the HITAC and, subsequently, to ONC that really can move the needle a bit here on USCDI Version 2 as that is prepared. I think we've heard pretty loudly and clearly from Al and from others at ONC that Version 2 is not going to be a huge change from Version 1 and that there are clearly some opportunities for us to have an impact. But I don't think it's going to be a revolutionary impact. I don't think we're going to go from six new items to sixty new items. And I think while we have just tremendous enthusiasm for lots of additional items to be added, I think we owe it to ourselves and to the community to really be selective and to really take the time to figure out what is going to be of the highest value. So, I think as we get into the spreadsheets today, I hope some of you have had a chance to spend some time with them. You'll see some new columns that we've added.

One is in reflection of conversations we've had here where Hans and Ricky and Clem and others have said, "Gee, if there is an item that's already well established and in use and as such is fully represented in both US Core and CCDA, why would we not include that in USCDI?" So, that's one kind of hypothesis that those things that are at that intersection of CCDA and US Core, we should have a low bar or a lower bar for suggesting that they be included in V2. So, we've added a column. And Hans and Ricky have spent a lot of time populating it to help us to see which items are, in fact, in that intersection so we can consider that as we go. Grace, of course, has done a lot of work adding items and detail. And we're going to try to get through as much of that as we can. Michelle also from the CMS perspective is here today with routine and support. And we've talked a bit about the potential benefit of aligning USCDI with CMS's needs. And I think we want to give Michelle a chance to talk through that and advocate for that position a bit today.

And then, I think at the end what we really want to start to do is start to prioritize because I think it would be ingenuous of us to just say that everything that we flagged for 1C should be included. I think we would have missed our mark. So, what I want us to do as we go through these is really think on the 1C items. Are they top priority, medium priority, or lower priority? Of course, they're all priority because we bothered to put them here We feel strongly about them. But I think what we want to do is find those of the highest value. And then, in the end, the sense I've gotten from Al and he's not going to commit is that we might be able to bring forward a dozen new items for strong consideration into USCDI Version 2. I'm not speaking for ONC. I don't think that's been stated definitively. But I think that if we can discipline ourselves to come up with roughly that number of items that we think are of the highest potential value for addition, I think that will serve us and our community well.

So, I just wanted to throw that out by way of introduction. Leslie, do you want to add to that?

**Leslie Kelly Hall**

I do want to add that in the actual justification for recommendations in our spreadsheet, I did add the applicable standards that were named in either the comment section or in the actual ONC documentation. So, please correct me if I do not get those accurate. And if I especially said need investigation, it was simply because I could not find them. So, please keep me honest. Thank you.

**Steven Lane**

Great. Thank you, Leslie. Okay. Any other orienting comments that anybody would like to offer before we dive in today? Great.

**Grace Cordovano**

I wanted to ask a question about the prioritization and what ends up, actually, in Version 2. And then, based on our recommendations, does that dictate what may become Level 2 and Level 1 for future versions?

**Steven Lane**

Again, our task is to make recommendations about what's going to be in Version 2. We have not been asked or tasked with the job of focusing on comment level or Level 1 items. I think when we get past our first bit of work and we're focusing in on the process and providing input for that is an opportunity for us to come back and talk about, as we've said, guiding principles. We can, certainly, collect some suggestions for things. But I think a lot of that oh, it's a comment and it should be Level 1, it's Level 1, it should be Level 2, I think, really those are comments that we should be placing individual onto the website as public comments in support of individual data elements. I don't think we're going to add a lot of value doing that here as a task force. But we can talk about that when the time is right.

**Grace Cordovano**

Thanks for clarifying.

**Steven Lane**

Yeah. Al, do you want to add to anything that I've said?

**Al Taylor**

Yeah.  No. I think I want to sort of clarify what Grace's question was by asking another question. Are you saying that the HITAC recommendations could directly change the level determination and, therefore, the consideration for adding to Version 2? I ask that because the prioritization criteria don't affect the level. The prioritization criteria are applied to Level 2 data elements to determine which ones go into USCDI. So, as part of the process review that Steven was talking about for Tasks 2 and 3, making recommendations for or against the evaluation criteria or the level criteria that we've set would also be useful input. But it wouldn't affect it this time around.

**Steven Lane**

Thank you, Al, very much. And that's for the question, Grace. On the first spreadsheet that we had, the USCDI task force recommendations, I don't see that anyone has added any comments to that spreadsheet in a couple of weeks. But I want to make sure that we don't miss anybody's input on those items that we

spoke about earlier. Does anyone have a recollection that there was something on that spreadsheet that they particularly wanted to revisit? Great.

**Grace Cordovano**
Are you talking about the editable or the non-editable, Steven?

**Steven Lane**
The non-editable. It's called USCDI task force recommendations.

**Grace Cordovano**
Just clarifying. Thank you.

**Steven Lane**
Yeah. So, let's go then to the member recommendations editable spreadsheet. And there were a couple of items that I just wanted to be sure that we covered, again, generally going in order of our tasks. But Michelle, I think that you entered an item that is flagged as Task 1A, which, again, is relevant to data classes and elements from Version 1, including their applicable standards version updates. And that's on Row 3. So, Al, I don't know if you can get the spreadsheet ready to share. But we're going to focus in on that. So, Michelle, this had to do with problems, the use of ICD-10 terminology, and CMS recommending adding terminology to the problem data class. I think this is a pretty easy one. Do you want to just go through this quickly so we can clarify our position?

**[Crosstalk]**

**Steven Lane**
You want to be on Row 3. There you go. Thank you. Michelle?

**Michelle Schreiber**
Steven, I'm saying thank you. That's exactly that it's just our recommendation that for problems, we have all talked about problems in the problem list that we add the ICD-10 so that we can be able to track that and make sure our quality measures are based with their specifications written by the ICD-10's.

**Steven Lane**
And I've heard this bit of feedback from others as well in the community. Al, do you want to comment on where this is at with regard to the applicable standards?

**Al Taylor**
There has been debate for years about whether or not problems ought to include ICD-10 and because of the historical reasons for using SNOMED only for problems. And it's in that vein that we advance the encounter diagnosis, which would be applicable standards for encounter diagnosis would be ICD-10 or SNOMED. In part of our guidance for the certification in the certification criteria for being able to capture and exchange problems, we do talk about the mapping between SNOMED and ICD-10 where systems might only be able to record if systems can only record or are only recording diagnosis or encounter diagnosis and they don't capture SNOMED then, there is a mapping operation that can be done to map to a SNOMED code to meet the problem data element criteria for cert. So, we have talked about that in the

past and we're, obviously, open to recommendations about it. But there was discussion about this particular issue as far back as the 2015 certification rule.

And we ended up landing on problems being represented only by SNOMED.

### Steven Lane
So, I'll chime in, Al, and really in support of Michelle's suggestion, I know that the EHR that I use primarily leverages ICD as a coding mechanism for problems on the problem list. You can take an encounter diagnosis and just flag it to be added to the problem list. You can take a problem from the problem list and resolve it over to the past medical history. While I think we do have mapping to SNOMED in that background from the clinician's perspective and from the patient's perspective, I think the primary coding that we're looking at is ICD-10 at this point. So, it does seem a little odd that ICD-10 is not included as an applicable standard for problems on the problem list. So, curious what Clem has to say about this.

### Clem McDonald
If I don't get disconnected, let's see. Can you hear me?

### Steven Lane
Yes.

### Clem McDonald
Okay. So, the reality in most households is that it uses a commercial product, I won't promote the product, that converts what physicians say into any code. And there is relatively little internal use of SNOMED in the US, except for two or three major institutions. So, people have to use ICD-10 so that has entitlements. And the second thing is that ICD-11 is coming. And it's much more attractive than ICD-10. So, I'd be supportive of what Steve said that we should allow it. And if ICD-11 is as good as it might be, we could have a simpler world.

### Michelle Schreiber
Steven, I'd like to comment, too, and see, Clem, how you feel about this. I could see that one of the goals is concurrent coding that people are constantly looking at how can we do concurrent coding through encounters. And starting with the ICD-10 and this problem seems to help to make that more of a reality.

### Clem McDonald
Yeah. I agree with that.

### Steven Lane
Any other thoughts on this one? Does anybody feel that the task force should not support this recommendation?

### Mark Savage
Steven, this is Mark. I do not oppose. I think it's a good idea. I'll just flag that the Gravity Project social determinants submission also uses ICD-10 for problems. So, it's further alignment.

### Ricky Bloomfield

And just to clarify, this is Ricky, is the proposal here to add ICD-10 as a requirement in addition to SNOMED or encourage? What's the exact proposal?

**Steven Lane**

Michelle, you brought this forward. Do you have – obviously, we could say it's allowable or we could suggest that it be required.

**Michelle Schreiber**

Well, the truth is, I guess, we would want to suggest that it's required and don't understand why we want the rework of having to map to something else in the background, especially when, quite honestly, providers understand ICD-10 better than they understand SNOMED. And within functionality, you're right, Steven. It's doing these **[inaudible] [00:18:42]** concurrent coding using the ICD-10. So, I guess we would want it but, at a minimum, we'd like it allowable at least.

**Ricky Bloomfield**

One consideration here is that the large health systems often have the capability of doing this translation. As Clem mentioned, they have software that makes that fairly easy. But if this is made available through an API, smaller app developers, typically, don't have that capability and they may have a preference for one or the other. So, I would say that if this is included, it should be in addition to SNOMED, not as a replacement for it. And, certainly, both coding systems can be provided for any diagnosis.

**Les Lenert**

This is Les. I think it's wise to take a stand on this. And if you try to write software that does both SNOMED and ICD-10, it just gets complicated in that you're, essentially, saying every piece of software has to have the mapping tables in it between the two, which are one to many relationships and pretty complex. So, no. I think it's one way or the other really and we should take a strong position.

**Steven Lane**

And which position do you suggest, Les?

**Les Lenert**

ICD-10.

**Steven Lane**

Okay. I just wanted to be absolutely clear there.

**Les Lenert**

We have to be pragmatists. ICD-10 is the pragmatic choice. SNOMED is the idealistic choice right now perhaps for a global unification that may one day happen.

**Steven Lane**

So, I think though, clearly, when we're talking about Version 2, which is going to be published later this year and expecting all applicable vendors to make a wholesale shift from SNOMED to ICD that could be challenging. So, I guess I'd ask if any of the EHR vendors would like to weigh in on how challenging such a shift would be.

**Hans Buitendijk**

This is Hans. I think a couple notes are that frequently, it's been a problem. So, you might see more SNOMD. And in encounter diagnosis, you will see more ICD-10. So, I'm not convinced totally yet that we have to go for one only or everything ICD-10. But there is also a lot of translation going on that if one has issues, the other one is at it as well. And it might vary based on EHR. So, I think I'm not convinced that we should go to everything must be ICD-10 and you cannot use SNOMED anymore. I think that you will see in whether it's in documents or US Core already in the profile for condition, it already supports both SNOMED and ICD-10 and not yet ICD-11. But I think we need to be a little bit more flexible there. And for the purpose at hand, we'll use ICD-10 when you go into reporting or billing or quality measures and you go into SNOMED where that's needed. And you're going to go back and forth. Not a perfect one on one match but I think that's more practical.

**Leslie Kelly Hall**

I think Ken has a comment.

**Ken Kawamoto**

Yeah, thanks. So, I think given that if currently something is required, we should be very, very hesitant to say you have to make a change. I think that's a problematic issue. And the vendors represented on this call may not be representative of the less resourced EHR vendors. So, I think we should be very, very careful about saying something that we required and you expected and you built things of off, just kidding, we're changing it. I think it's probably fine to say yes, ICD-10 is also acceptable for these purposes. I think that's probably reasonable. But I would definitely not say something you used to be able to use but you can't use anymore.

**Al Taylor**

I wanted to add another point. I can't see hands so I don't know if I'm talking out of turn.

**Steven Lane**

No, go ahead.

**Al Taylor**

Because future versions of USCDI that are adopted through the standards version advancement process are all going to be voluntary until another round of rule making, whatever requirements are in USCDI Version 1 the last incorporated by reference standard that ONC has put out through rule making that requirement will always be the requirement until changed by a future rule. And so, recommendations to remove SNOMED as an applicable standard from problems isn't going to have any impact at all because EHR's will always be required to support SNOMED until rule making changes that.

**Clem McDonald**

Could I just clarify something?

**Steven Lane**

Go ahead, Clem.

**Clem McDonald**

I didn't hear anyone saying to disallow SNOMED. I think the positions were either allow ICD-10 as well or require ICD-10 as well. Those are the two issues, I think. And maybe CMS took one position and maybe they should speak to which one they want or somebody else should.

**Michelle Schreiber**

We would want both ICD-10 and SNOMED. On the other hand, that's not what we get. Saying it's allowable, at least, is a first step.

**Leslie Kelly Hall**

Hans and Grace have comments as well. Hans?

**Hans Buitendijk**

Yeah. I would like to ask a little bit more clarification. From earlier discussions, I thought that if you opt voluntarily to use USCDI Version 2 that's in your certification at that point in time as well that you have to conform to the entire USCDI. And if USCDI V2 were to include ICD-10 only and not SNOMED besides the comment just made, which I agree with, is that you would, therefore, not support SNOMED. You have to support ICD-10. And you would not support SNOMED per se. So, that's where I'm not sure what it means that you still have to support SNOMED because that's not in USCDI V2 at that point in time, unless we put both in.

**Steven Lane**

So, I don't want to spend too much time on this because we have so much material to cover. I think that it's pretty clear where we stand on this. We think ICD-10 should be allowed. There are various ways that the ONC could do that. They could just say it could be there. They could say it must be there. They could, eventually, switch over if that seemed appropriate. Al, what were you going to say on that?

**Al Taylor**

I agree with you about not spending too much time on it in this meeting because this is a certification question about what the impact of adding it to a requirement versus replacing it as a requirement. That's not an easy certification question to answer.

**Steven Lane**

Grace, did you want to close this out?

**Grace Cordovano**

Yes. I just wanted to know, regardless of which way we go, whether it's to allow or to require, I understand that certain vendors may not have the resources or capabilities as smaller vendors. I'd like to see if the task force could comment on what would bring the most benefit to patients in the long term. Is there a difference between allowing and requiring and is that the lens we should be looking through?

**Steven Lane**

Does anyone have a thought on that?

**Leslie Kelly Hall**

I do. This is Leslie. From in terms of the patient, the advantages of adding ICD-10 to this option is transparency all the way through the billing. And that can be very, very important. When an person is trying to decipher these different things, it's inconsistent information and it becomes difficult. So, I would agree that ICD-10 should be added and also that, to Michelle's point that at a future date we could consider whether one is sunset or not but if there is huge support for ICD-10 and a variety of workflows and for transparency.

**Steven Lane**
Perfect.

**Al Taylor**
Can I just add one more comment?

**Steven Lane**
Sure.

**Al Taylor**
As far as patient access, in particular, USCDI Version 2 does advance the addition of ICD-10 and SNOMED for encounter diagnosis, which is a specific additional data element requirement for view, download, and transmit, which is the patient access certification criteria. So, to say it's already in there and the ability to capture and exchange ICD-10 is already built into what we have added to Version 2.

**Steven Lane**
Great. Thanks, Al. Okay. I want to move on.

**Leslie Kelly Hall**
I would just like to say this is a great process question for our future work about sunsetting and adding and requirement.

**Steven Lane**
And Hans, I'm guessing that the Cell 3N would be a yes that the ICD-10 for problem misdiagnoses would be supported by both CCDA and US Core. Is that true or can you populate that cell for us?

**Hans Buitendijk**
I'll populate it. But for US Core, definitely. I was going through CCDA documentation, which you have to go through many documents to figure it out. I just need to double check whether that's correct. It's not that you could not do it, I think, but there's something weird about it.

**Steven Lane**
Thank you. Okay. So, that was 1A. We were just sort of backing up there with Michelle. Hans, you have added – let me see. I think we went through this. I'm not seeing a task force recommendation on Row – I'm sorry. The rows are so tall. I'm having a hard time seeing them all.

**Clem McDonald**
And the font is very small.

**Steven Lane**

Yeah. I don't know. AI can zoom in for sure. So, Row 5 is a Grace item. We discussed but didn't come up with a recommendation. That was date of resolution. We're going to come back to that.

**Michelle Schreiber**

Steven, I'm sorry. Can we go back to encounters? Is that the row above?

**Steven Lane**

Can you give me a row number? Encounter diagnosis, Row 4, are you talking about? The one we were just –

**Michelle Schreiber**

I just wanted to make a couple of comments around encounter. I know we've spoken about encounter and we've spoken about the data elements of time diagnosis and type. But CMS had also made a recommendation and I don't know if it got in here or if we put it somewhere different for location of care. Not the location of the provider, the location of the care as well as encounter disposition. Is that reflected in here?

**Steven Lane**

I think it is but I'm not sure which row it's on. So, I don't want to take our time going and hunting for it. We'll stumble upon it when we get there. Okay. So, Michelle, I think that we should be on Row 6, actually, which is part of what you were just talking about. We have a task force discussion around encounter time but we don't have a recommendation that came out of that. And I want to drive to solidify our recommendations. So, Michelle's member recommendation was CMS recommends inclusion of encounter time, this is 1B, to ensure ability to identify start/end of encounters, including admission and discharge date times. We had a long discussion about justification.

**Leslie Kelly Hall**

I think Clem had a comment to this, too.

**Clem McDonald**

Well, it's really a clarification. So, when we say time, do we mean date time? Do we mean exact times or just the dates? That's one question. And the second one is that I don't know that it's going to be – for hospitalization, it's always been admission and discharge. It's not as clear in other circumstances like a visit when they come. I don't know if people keep track, except it's on one date. So, I just need some clarification of what's desired.

**Michelle Schreiber**

I think for hospitalizations, you're right. It's admission/discharge. But there are other places like the Emergency Department times that are important, times of admission, times of deciding to admit somebody, times of discharge, times of getting to the floor. So, there are a number of other start/stop times that are important.

**Steven Lane**

Are they collected? That was the question?

**Michelle Schreiber**

**[Crosstalk]** – hospitals.

**Steven Lane**
So, again, this was 1B meaning that it's something that was included encounter time in Draft V2. So, there were two questions here. One is should it be date plus time. We can weigh in on that. And the other is should there be both a start and a stop time. Obviously, there are a multitude of times that could be included. But I think we have to start somewhere. And it seems that what you're mostly interested in, Michelle, is how long was the encounter be it an inpatient stay, an ED encounter, etc. So, it seems like date and time and start/stop times would be the things that we may want to weigh in on. Does anybody feel that it would be inappropriate for us to suggest, including both date and time and both a start and a stop time knowing that that's going to be a stretch, I think, for a number of vendors that put that in?

**Leslie Kelly Hall**
Sasha has a comment.

**Steven Lane**
Sasha?

**Sasha TerMaat**
Hey, folks. So, we, actually, talked about this with EHRA and we had a lively conversation. As Michelle points out, start and stop times are used in quality measurement today. The challenge with including it in USCDI where it might be used for purposes beyond quality measurement, too, and we wanted to be cognizant of that, is that while there is a high degree of precision as to the start and stop of a hospital encounter or an Emergency Department encounter, those are concepts that have a lot of definition and consistency across the industry. The same is not true of outpatient office visits. And we do not have a lot of precision as to the start and the stops of the encounter. And today in quality measurement, different EHR's use different, I don't know, approximations of that, maybe the scheduled appointment time and the scheduled duration. Some folks are, actually, measuring time spent by certain people in the chart. But those are getting at a concept that just doesn't necessarily have a lot of standardization today.

My recommendation, which I think my colleagues in EHRA were amenable to would be to focus on the outpatient ambulatory side on just the date of the encounter. And on the inpatient side where I think there is a high degree of standardization, I think using the start and stop time is very reasonable. But I don't want us to include start and stop times on the ambulatory side that are misunderstood. Where if we're using like it's scheduled at 9:00 and it's a 15 minute visit and then, the patient looks at that in an app and is like, "But my visit didn't even start until 9:30. That doesn't make sense because it was running late." We don't necessarily have the consistency of understanding of what that means that we do on the inpatient side if that makes sense.

**Leslie Kelly Hall**
Jim also has a comment to add.

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**Michelle Schreiber**

Just one comment. From a CMS point of view, ED is ambulatory. So, I would want us to exclude ED here.

**Sasha TerMaat**

I think the Emergency Department has the precision that I would, typically, see on the inpatient side. So, yes, let's make sure we're clear that, in my mind, Emergency Department, inpatient, they have a lot of specificity around start and end. Whereas an office visit, not an Emergency Department office visit, is where, I think, we lose some of that specificity on an exact start and stop sign for a routine visit.

**Michelle Schreiber**

No problem with that.

**Leslie Kelly Hall**

Jim, did you want to add something?

**Jim Jirjis**

Yeah. I wanted to concur with the comments just made about the precision. And to me, the question is if it's included in USCDI, what does that one day mean as far as whether it's required that you report it? And the reason I say that is even in the ER, there is a little bit of fuzziness about was it the time they checked in, was it the time to greet. But particularly in the clinics, it's going to be a problem to include time. And my only question was why do we need time for any of it? Why can't we leave it at date? Because the mischief that will come from all of the downstream secondary interpretations of time when there is not much precision, to me, seems a greater risk than the benefits of trying to include time. People making conclusions about somebody's throughput, etc. – my vote would be why not Version 1 start with simply date of admission/discharge.

**Al Taylor**

Date would be one way to implement encounter time. Date/time would be another way to implement encounter time. Admission date and time or admission date would be one way to implement encounter time. And it's unlikely ONC has consistently had flexibility as far as how to implement any given data element. And it depends on the use case. So, if we're talking about ED start/stop time, if we're talking about an inpatient admission day, there are different ways of implementing time or timing. And date could be a time. Date/time could be a time.

**Jim Jirjis**

I get it. So, to me, it seems like if we're wanting to provide the flexibility for detail for those use cases but not require it and allow flexibility to just do date and be compliant then, it makes sense to me, from my point, to include all of it but realizing that it's not required that a certain level of granularity like time stamps are part of the science.

**Al Taylor**

And that's why we left it at the encounter data element of encounter time.

**Leslie Kelly Hall**

Grace had another comment as well.

## Grace Cordovano

I'm just wondering if it would be helpful to capture this under procedures or surgical because that's where really the time is most accurate and most meaningful for **[inaudible] [00:39:59]** and billing. Are we looking at the right framework broadly putting it under encounter information? Should it really be under procedures perhaps?

## Steven Lane

Again, that wasn't proposed. So, that's not in scope for us now. That's something that could be proposed later. So, I'm trying to push us through.

## Leslie Kelly Hall

We have Daniel as well.

## Steven Lane

Okay. Go ahead. Al, if you can display the recommendation text that I have.  There we go. That would be ideal so we can be commenting on that. Go ahead, Dan.

## Daniel Vreeman

Yeah. I want to support the seeking support of the recommendation. In part, it's important to clarify this begin and end with the flexibility that's been discussed. But leaving the reference to just time is not so clear because time is really a duration. And, actually, what we're interested in is the fact that there is, typically, a start and an end, which looking at the way FHIR or US Core and I believe CCDA as well represents this, it's a period data element, which has both the start and an end component, which the end is optional and, actually, the start is, too, with that flexibility that Al was just describing meaning the actual representation can have super precise stuff but it can also simply be a date. And I think that's exactly what we want. But the clarification that there is a start and an end, in many instances, I think, is important rather than leaving just the words time.

## Steven Lane

Hans?

## Hans Buitendijk

I would support Dan fully on that.  As we are trying to indicate at least you can support a date, the term time is going to be confusing. And we also have to be careful that while a date is for USCDI the starting point that there are settings where more precision is appropriate. So, I think period, I would completely begin with that it's a better term. It covers better and then, allows that as we get into the standards and the actual individual use cases, whereas quality measures, billing, otherwise that the appropriate level is understood much better but that the general concept is encounter period that at least resolves and addresses the date.

## Steven Lane

Okay. So, I have a recommendation that says, "Include date and time to the minute at least for acute care encounters, including hospital and ED. Require encounter start/stop times for inpatient ED encounters. And would need to specify precisely what times constitute start and top times for these encounters." Does

anybody disagree with that as a recommendation? All right. Let's keep going. All right. I want to shift to give the floor to Michelle to give an overview of your items. Again, I'm trying to slowly or not so slowly narrow into what will be our recommendations. And I fear that if we're going line by line, we're not going to get through everything here. So, I want to come up with some guiding principles for us. We've got Column N now with the CDA, US Core intersection. I think Grace has spent some time talking about, generally, the items that she's entered. And I want to give the same opportunity to Michelle. And then, we can go back to the line by line work.

**Michelle Schreiber**
Thanks, Steve. We've done the first two that were on our list. I want to talk about one more thing about encounters. And that's disposition. Certainly, to disposition covering the hospital discharge disposition such as home, post-acute care, hospice. But otherwise, including disposition from another part of the hospital such as disposition from the ED. So, again, it gets back to for CMS, the ED is seen as something that is ambulatory. But longer term, I know we had this conversation. We also believe we need disposition from other facilities such as a SNF to home or to home health or to hospice and so forth and so on. But starting with the hospital and the Emergency Room is something we'd like to advocate for. The other thing we want to make sure to include is identification. And I know we've had lots of conversations about identification as an NPI. But just to put a few more out there for consideration, one is the TIN, which is the tax ID number, which defines a group.

Billing is done by that and a lot of quality measure reporting is done like that. Supporting the addition of a patient's identifier such as the Medicare patient ID. And if there are other appropriate payer ID's that are important, for us that would be important to have so that as we're looking at patients, this is another way really of identifying a patient. And finally, we'd also like to recommend including the health insurance coverage type as another identifier. And I think, frankly, that's useful for patients being able to see that as well.

**Steven Lane**
Michelle, to orient us so that we can capture the discussion of these points, can you point us to specific rows where you've put these in? I found Row 11 where Leslie had, initially, suggested including encounter time, type, location, disposition, diagnosis. And I think that's where you were when you said that you desire disposition information from SNF facilities. But I just want to be sure.

**Michelle Schreiber**
Yeah. That one is fine. I don't know where identification is. The next ones that I'm going to do start at Line 33. I'm following the spreadsheet on your spreadsheet because I only have so much screen that I can open.

**Steven Lane**
Yeah, okay. So, Line 33 is encounter information, encounter location, which you recommended including in V2. Now, interestingly, if we look over at Column N, what Hans and Ricky tell us is that this encounter location is a must support in US Core. It's not required in CDA. And it's not certification tested for CDA. And here again, I don't know that this is an absolute criteria for us to recommend something be advanced to V2 but it's, certainly, very nice to have. I think we're going to have a harder time advancing items to V2 that are not well specified in both US Core and CDA. Clem?

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**Clem McDonald**

Yeah. Just some clarification again. So, what location is isn't clear to me. We have setting. We've got location, the physical location and we may have this thing virtual or not. So, I just think we need more clarity. I'm not sure what we're talking about always here. And the other thing, I think, when we think about setting, I don't want to reopen the other discussion but there are different issues with psychiatric encounters because they link them together and with nursing home encounters and other kinds of encounters. So, I don't want to reopen that wound. But we should probably specify a setting when we decide what we're going to do and take a couple of them and not try to swallow the ocean.

**Michelle Schreiber**

And our recommendation is hospital and ED.

**Steven Lane**

Okay. So, when you say hospital and ED, what do you mean in terms of location? Just name of hospital, address, what exactly are you looking for?

**Michelle Schreiber**

Location is, actually, hospital, office, ambulatory, surgery, and home. I was thinking of disposition. But in particular, if we had to vote for something, it's hospital and within the hospital, particularly ED and ICU and Cath Lab.

**Clem McDonald**

Are those settings? CMS defines it as a list of settings, I think. Maybe I'm mixing it up.

**Steven Lane**

Michelle, can you point to the specific data element or maybe Sasha knows this off the top of her head?

**Leslie Kelly Hall**

Hans has his hand up as well.

**Steven Lane**

Good.

**Leslie Kelly Hall**

Hans?

**Hans Buitendijk**

Sorry. Yes. A consideration with some of these where one standard or implementation guide is already supporting it with the guidance and the other one not quite. It's not that it could not handle it. It's not just that the guidance is not there. Another consideration would be is that if we don't consider it for Version 2, can we already start to signal as part of our next part of the process that these kinds of things that are supported in one standard and where they need to be in sync, those are likely candidates where people can start to work towards that and get that ready for the next round. So, just as a procedural question to consider to help make decisions on what to recommend or not. Clearly, when one supports it and the other one doesn't or clearly has the guidance for it but the other one doesn't, the data is there. They work together.

**Sasha TerMaat**

To add on, I guess I'm still a little bit confused. I would think of location as address. And it sounds like we're, actually, talking more about a value list of particular care settings. What are we, actually, contemplating here?

**Clem McDonald**

Thank you, Sasha.

**Michelle Schreiber**

Sasha, from a CMS point of view, you're right. It is a facility setting. It's not address. So, it's hospital/ICU or hospital/Cath Lab. And you can go outside the bounds of a hospital but you don't want **[inaudible] [00:51:22]**. Those would be the key ones.

**Steven Lane**

So, you're saying it's setting, not address. Is that correct?

**Michelle Schreiber**

Correct. It is location of the service but not the address of the service.

**Leslie Kelly Hall**

Michelle, this is Leslie. I had a question. Is that well defined when a patient moves within setting to setting inside a hospital? ED to inpatient seems that going to a rehab facility that's co-located or moving from ICU to step down, how do you contemplate that?

**Michelle Schreiber**

I'm going to have to rely on Sasha for this. I think those are defined.

**Sasha TerMaat**

Gosh, I've got to check with a colleague and phone a friend on that one. I think you would know when people are going to Cath Lab but I've got to check.

**Jim Jirjis**

It's Jim Jirjis. Are we talking about the precision and accuracy of the time stamps?

**Steven Lane**

This isn't time, Jim. We're on location now.

**Michelle Schreiber**

This is just location.

**Jim Jirjis**

Oh, I'm sorry. I had to take another call. My apologies.

**Steven Lane**

Yeah. And feel free to use the hand raising, too, Jim. But go ahead.

**Jim Jirjis**
Oh, sorry.

**Michelle Schreiber**
So, we might know movement but it might, for instance, to your point, Sasha, someone goes to a Cath Lab, they're not, actually, moved to a necessary setting in care. They have an order to appear for a particular test, which then takes place. So, I think there is a lot of ambiguity, even within a hospital. And I'd like to hear others' comments as well.

**Sasha TerMaat**
Part of the challenge is that location is, in some senses, a metadata about another thing. It doesn't mean that much independent. So, we're going to associate this setting with a particular encounter. If the encounter is at the level of the hospitalization then, the setting metadata, it sounds like from Michelle's thing, might, actually, be multiple because at the level of the hospitalization, which is the encounter that we're associating this with, you might have an admission that also includes a visit to the Cath Lab. And I think that's where it's starting to get tricky. Whereas if we were trying to associate setting with a procedure, it might be different than associating setting with an encounter if that makes sense.

**Leslie Kelly Hall**
So, Steven, it sounds like there is enough ambiguity here that we don't have agreement.

**Steven Lane**
That's the sense that I'm getting as well.

**Clem McDonald**
Me, too.

**Hans Buitendijk**
And I'm checking FHIR and CCDA. There are some fields that might cover it. But depending on the vocabulary exactly being used, it might not. So, if it's meant to be setting more, we need to check a little bit further of what's already there.

**Steven Lane**
So, Clem, you've got your hand up.

**Clem McDonald**
Yeah. I think there are a couple of problems here. One of them is we don't have fixed lists. We're not quite sue what universe we're talking about. And then, when you get down to these really micro steps in an institution, I don't think people are able to capture that. So, there's a whole different story talking about steps from here to there. There is machinery that could do it but I don't think it's likely used.

**Steven Lane**

All right. So, what I'm going to say in summary is that it's great that this made it up to Level 2. And it does sound like there is still work to be done. Leaving it in Level 2 does flag the industry that this is something that ONC is considering. But I don't think we have consensus here that this should be elevated to V2 at this point. Is that accurate?

**Hans Buitendijk**
I think that's fair. But just for clarification to avoid the confusion of what the location means. What's really the intent behind it that we'd have to clarify to progress it?

**Al Taylor**
And just for everybody's assistance and guidance, I did add the data element definition as submitted for encounter location in the chat window. I'll try to do that as these come up.

**Steven Lane**
In the public chat? Somehow, I don't see that. Al, feel free to add that to the spreadsheet I would say. So, I'm just going to try to go as we go. I'm going to call this Task 1C Priority 3. So, this is a lower priority for us in our consideration than other 1C's. So, Michelle, do you want to point us to another one here so that we can give you a chance to make your case?

**Michelle Schreiber**
I'll start at Row 34. We can just take them in order. Let's go to Row 34.

**Steven Lane**
Great. Go ahead. This is encounter disposition.

**Michelle Schreiber**
I think we talked about this one already, the encounter disposition. So, keep going.

**Steven Lane**
Well, we talked about it but we want to come to a recommendation. We don't want to keep revisiting these. So, you're right. This duplicated one that was up above. Again, I encourage all of you to try to find the same item. If it's already there, don't keep adding the same item in multiple places because we'll never get through it all. So, here we go. I found what we talked about that you desired disposition information from SNF facilities. Was there anything more you wanted to say about that?

**Michelle Schreiber**
Hospital disposition, ED disposition and, eventually, long term care facilities as well. That's fine.

**Steven Lane**
So, this is on Row 34. Al gave us the data element.

**Sasha TerMaat**
I think this will matter for the other one we said was just applicable to hospital versus offices also. How will that be handled in certification? If you make a product that's used in dermatology offices, it may not be practical to capture encounter disposition if we're deciding that's primarily relevant for hospitals and long

term care and Emergency Departments. You might be able to view it if you got a record from a hospital but you wouldn't necessarily capture it. Do we have the certification complexity to address differences by setting yet? Or is that a prerequisite to adding this type of data class?

**Al Taylor**

Sasha, I don't know if that question was to me or to the group.

**Steven Lane**

Why don't you go ahead, Al?

**Al Taylor**

Well, there are some situations in which we distinguish between different care settings for certification requirements. And that's tested through the different test data. We've got ambulatory, inpatient test data for certification and testing. And so, we have not, to your question, Sasha, about whether or not we could specify certain criteria or test data for a very specific particular care setting subset of ambulatory such as dermatology or not, it's unlikely that we would be that granular in our test data and testing. If we did specify or narrow down the care settings for testing and certification, it would likely be at the level of ambulatory versus inpatient, possibly ED as a different kind of care setting.

**Sasha TerMaat**

That's helpful. I guess to give my perspective, I think that as we've discussed before, the concept of encounter disposition has standardization in the inpatient context that is not present in my version of ambulatory context, not thinking about the Emergency Department. And so, if including this in Version 2 means every dermatologists' product and every dermatologist is now expected to somehow have this concept, I think that's a big lift and something we would need to consider more. If we have a way to differentiate and say where we have consensus on this concept at a hospital discharge, let's include it and share it through USCDI, I think that's a more reasonable thing to include in Version 2. So, I think if we have the flexibility to accommodate in certification so that we're not forcing every specialty product used in different office settings to have a concept that they haven't maybe had familiarity with today then, it will be okay. But if we don't have that flexibility in certification then, I think we need to hold off on this data element until we reach that degree of flexibility.

**Steven Lane**

So, what I'm hearing is a recommendation that I tried to capture here to include encounter disposition in Version 2 for hospital and ED encounters and to somehow signal that this will, in the future, be included for long term facilities or should we as for that in Version 2 as well?

**Michelle Schreiber**

I think we can signal it in the future.

**Steven Lane**

Okay. Does anyone disagree with this approach? All right. I have captured that. Michelle, did you have another one that you wanted to focus in on?

**Michelle Schreiber**

What's the next one down?

**Steven Lane**

Oh, wait. I'm sorry. We didn't prioritize that. I want to prioritize this. So, encounter disposition, the inclusion for hospital and ED encounters, do we see that as highest, more medium, or lower for our suggestions?

**Clem McDonald**

It's high and it's mostly out there done. I think most of the people report it.

**Steven Lane**

Well, we do have the note in Column N that US Core is marked as much support. CDA is not required and not tested.

**Hans Buitendijk**

But I think it goes back to the data is there. Otherwise, US Core would have a problem. So, this is one of those balancing areas is that we think that V2 that we can start to then expect it in CCDA's as well or we need a little bit of extra work for the guidance on where and how to do it.

**Steven Lane**

And do we feel that selecting or promoting an element that is not yet in the CCDA that that's reasonable? Is that a good idea?

**Hans Buitendijk**

It is in CCDA in the guide. But it's not currently part of the wide capabilities of CCDA to include that. So, that means that not everybody may have done it. So, do we feel that putting it on V2 is sufficient to **[inaudible] [01:03:54]**? In FHIR, it's already a must support for hospitalization topics.

**Steven Lane**

I see. It's in the CCDA. Okay. So, am I hearing this as a top priority one, encounter disposition for hospital and ED? Very good. Sorry. Michelle, next one.

**Michelle Schreiber**

Okay.  That was Row 34. Is that correct?

**Steven Lane**

That was 34, yes.

**Michelle Schreiber**

So, 35, hopefully, is straight forward. This is identification and this is adding the Medicare patient ID.

**Steven Lane**

This is the facility ID, 36.

**Michelle Schreiber**

I was on 35 and 35 is the patient.

**Steven Lane**
Okay. Sorry.

**Clem McDonald**
I'd like to comment if I could.

**Leslie Kelly Hall**
Go ahead, Clem.

**Clem McDonald**
This is something everybody wants. And I guess the only concern is is it allowed. If we could get clarity that it's allowed, I would be very supportive of it.

**Leslie Kelly Hall**
Clem, it isn't on Medicare identity. It's on a general patient identity. And I don't know how that applies. Al might be able to talk to that. When I tried to find the standards and, Michelle, I'll need your help on this or Hans, I'm looking for a Medicare specific standard and I didn't know whether a Medicare specific standard for identity can be taken out of context of overall patient identity or are we talking about all types of patient identifiers. So, I'd love some clarification as well.

**Michelle Schreiber**
This is the specific patient identifier. And I can go back to our group and get even more clarity.

**Clem McDonald**
But it would be terrific if we could get this widely adopted for many, many purposes.

**Michelle Schreiber**
Absolutely.

**Clem McDonald**
Whether it collides with something else is what we've got to find out.

**Steven Lane**
So, what I think the ask is from Michelle is if the patient has a Medicare patient ID, an MDI that that be transmitted as part of the US Core data set. We're not talking about other patient identifiers but, specifically, the Medicare patient ID. Does anyone feel that that would be a problem?

**Clem McDonald**
Well, again, I think it's a good idea. But I wonder whether we should have a field named that or have a field with the type. Sorry for getting off the subject though.

**Hans Buitendijk**
So, that means that for every transition of care or any access that then, the MDI becomes available. And if we feel that that is appropriate and acceptable to be exchanged to that extent. If not then, at least that

clarifies that while it's, generally, in USCDI so there has to be the ability for certain use cases to support it, we might still need to indicate that there is guidance needed as to when or when not to include it if there is a concern.

**Michelle Schreiber**
I will go back and make sure there is not a concern on CMS's part.

**Steven Lane**
Okay. We will not come up with a recommendation for this one yet.

**Michelle Schreiber**
We think not but I want to verify that.

**Steven Lane**
Okay. Michelle, bring this back here when we meet next time.

**Michelle Schreiber**
I will. Thank you. The next one is Row 36 is the facility identification. For us, that's the CCN number, which is the billing number. It's a facility number. And there may be other facility information numbers but this is the one that we particularly support.

**Clem McDonald**
I just want to clarify is this the NPI? Organizations have national provider ID's as well as people. Is that what we're talking about?

**Michelle Schreiber**
No. The NPI I thought was for providers. This is, actually, a hospital number. It's a billing number that Medicare uses. It's the CCN. I don't know what it stands for.

**Clem McDonald**
Well, NPI is for providers and includes the definition of hospital as a provider. So, are individuals. I think we just ought to clarify which is which.

**Leslie Kelly Hall**
It's the facility ID, correct? Sasha has some comments to add as well.

**Sasha TerMaat**
So, I have a question about what we're associating this with. If we're saying what encounter, for example, what CCN a particular hospitalization takes place in or what tax ID a particular office visit takes place in, I don't think it would be problematic to associate these at the encounter level. But, again, this is like a metadata thing. We've had enormous problems though with MIPS when the reporting involves associating things that don't really have a tax ID associated with the action like placing a prescription. And then, it gets very confusing because people will place a prescription and they're not necessarily thinking that their prescription is particularly associated with one tax ID or another tax ID the way a visit is in that way. And

that gets complicated. So, I guess, my question is the data element of the facility ID being the CCN or the PIN seems fine. But is the data class the facility level data or is the data class really the encounter?

**Leslie Kelly Hall**
It may be the encounter.

**Sasha TerMaat**
I think associating a tax ID or a CCN with an encounter where applicable is fine. There are going to be some types of encounters that potentially don't have either. So, obviously, we'd need to accommodate.

**Steven Lane**
So, this would be another one of those when it's available, consider it to be part of USCDI and require it to be exchanged.

**Sasha TerMaat**
Only associated with encounters though, yes.

**Hans Buitendijk**
And then, it's only encounters that the service providers and the organization that is providing that encounter, they're the CCN, correct?

**Sasha TerMaat**
That was my understanding.

**Steven Lane**
Okay. So, really, this is not data class facility level in Row G. This is rather going to be encounter information, correct?

**Sasha TerMaat**
Yes.

**Steven Lane**
Okay. And the data element. Now, the challenge though is what is the data element under the encounter information, the applicable data element for this suggestion then?

**Sasha TerMaat**
I would, actually, split these into two separate data elements and not try to generalize as facility organization ID but simply say TIN and CCN. And they're not analogous like in a product store those separately. They each have different formatting requirements. So, I would just have one encounter data element that was TIN and a different one that was CCN. And, of course, some encounters will have one or the other.

**Hans Buitendijk**
I would put on that that it's the encounter organization so that it can identify as the encounter organization identifier and then, TIN and CCN are the two that you're culling out. But it's the organization that's responsible for that encounter.

**Sasha TerMaat**
Yes. That's fair, Hans.

**Clem McDonald**
Could someone still explain how it relates to the NPI?

**Hans Buitendijk**
It doesn't.

**Sasha TerMaat**
It's not directly related to NPI, Clem. But NPI would, potentially, be an additional level about the person involved in a tax ID. So, MIPS, for example, is reported at the level of the tax ID and the NPI.

**Clem McDonald**
But NPI is applied to whole hospital systems, too. I look at the Medicare data. They cover two categories. They cover the whole system and they cover an individual.

**Sasha TerMaat**
I'm not familiar with that usage. When we identify hospitals today, it's typically by the CMS certification number of CCN.

**Clem McDonald**
Okay. But they exist. There are thousands of them.

**Steven Lane**
So, Clem, you've raised this point a couple of times and I don't want to ignore it. So, to be clear, what I'm hearing us coming around to is a recommendation for TIN and CCN to be added as data elements associated with encounter information in USCDI Version 2. Is that what people are saying?

**Leslie Kelly Hall**
Dan, did you have something to add to that or are you okay?

**Daniel Vreeman**
I was just going to clarify that the NPI at the facility level is a separate thing from the CCN. The CCN is about an organization's certification under Medicare and what services they're certified for. So, they sort of co-exist in certain contexts. That's all.

**Leslie Kelly Hall**
Thank you.

**Steven Lane**
All right. I think we have time for one more, Michelle, before we go to public comment at five minutes to the hour.

**Michelle Schreiber**

I'm just going to comment on Row 37 because it's really Row 38 that I wanted to get to and then, stop. Row 37 is just coverage type. So, if there is a way that we can include coverage type then, that's not just for CMS I would think. But I want to move further on that. I know you want to solve all of these. But 38 though is really high priority. And we've had a number of conversations already. We just want to support social determinants of health. We think this is a huge opportunity now to move equity forward in this country. It is a very big priority of the new administration. We're fully supportive, actually, of the work that Gravity has done. And we just want to support that and be sure that we're trying to include the data elements as defined by them.

**Steven Lane**

So, just to be clear and we've talked about this before, our task for 1C is to identify specific data elements that were included in Level 2 that we feel should be brought forward into Version 2. So, what specific Level 2 data element are you referring to here?

**Michelle Schreiber**

I think that there are structural standards that exist for some of these. So, we have race and ethnicity, which is already in Version 1. And we're recommending gender identity, sexual orientation, a consideration of disability status, transportation, housing, food insecurity. And I will stop there.

**Steven Lane**

Mark, can you comment? Sorry. Mark is an expert here.

**Mark Savage**

Yes. As Michelle has written it out under data element that was the second alternative that the Gravity Project submitted for USCDI and it is classified as Level 2. So, I understood your point, Steven, to be about scope. It seems to be within scope. There was maybe further discussion about the particulars. But as I understand it, it's in scope for our task.

**Steven Lane**

And this is the data element that she's included here. Assessment, goals, interventions, outcomes, problems, health concerns. That is the data element in question. Okay. So, that's the one that we've been talking about. This is the social determinants data element that made it into Level 2. And the proposal here is to bring that to Version 2.

**Clem McDonald**

Aren't these all observations as a class?

**Steven Lane**

Some of them.

**Hans Buitendijk**

Health concerns would be problems. So, some of them are observations. Other ones are not. And for some of them, Gravity has been doing a lot of work to get the FHIR profiling done and they are in flight. And some

areas in CCDA would have to be clarified. Some are covered. So, we need to dig a little bit deeper on what's already there and what still needs to be profiled or guidance developed

### Steven Lane
Sheryl, we'll get you in just a second. I just want to reiterate that when I look on the public website, Level 2 indeed SDOH is a class. And indeed it has five data elements defined in it. So, when Al and company went through the Gravity Project submission, they said these five data elements within this data class are good enough for Level 2. So, this is really the crux, if you will, of our whole social determinants discussion is whether we, as a task force, are going to recommend advancing these five data elements in one data class from Level 2 to Version 2. And I guess, Sheryl, your hand is still up. Maybe you can include in your comments whether you think that's a good idea.

### Sheryl Turney
Sorry. I think I was on mute. I think I listed because I added these to the spreadsheet a few weeks ago the six data elements that I pulled from the Gravity request that they felt were matured enough. So, they may be expressed a little bit differently than Michelle's. But I think it's the same data that we're talking about.

### Clem McDonald
I'm just confused by problems being a new data class. They're already in there.

### Steven Lane
Well, this is not problems, Clem. So, if you look at it, this is called problems/health concerns. And this was, in fact, submitted by Mark. So, maybe, Mark, you can clarify how this differs from problems on the problem list.

### Mark Savage
So, we created two alternatives. One is the way people often think of social determinants by the subject matter. So, food insecurity is an example. The other was by the activity used. So, assessment, problems, health concerns, etc. Gravity Project is working to fill in the value sets, the terminology that would be used for those. So, some of it is existing, some of it is new. And we are working to, as Hans said, in flight, already in the balloting process for FHIR implementation guide for clinical care. That's why it's listed here in the way that it is is activities. And I think that's why ONC said yes, it's Level 2.

### Clem McDonald
I saw an earlier version that was very explicit. And this looks very general.

### Mark Savage
There were two alternatives, Clem.

### Steven Lane
So, Clem, I guess I would invite you and anyone else who has questions about this to view the submissions of the individual data elements that are leveled at Level 2.

### Clem McDonald
Is that what's showing in this spreadsheet? It's too small to read.

### Steven Lane

No, it's not. Oh, there is much more. I will put it in the public chat. This is the link to where the details are included on the public website for the five data elements in question.

### Leslie Kelly Hall

What the recommendation would be then, Steven and Mark and Michelle, is that this would be moving to V2 and where this information was collected it would be available.

### Steven Lane

Okay. I've captured that as a recommendation. And Clem, I really want to make sure that you're fully informed on this. So, I think I'm going to flag this for us to come back to next week. Again, I see this as very important to our task force's work because I think this is one of the areas of greatest concern that we've heard from our community.

### Clem McDonald

I'm, generally, supportive. I can't be sure what this is as it's stated. I used to think I knew what it was.

### Steven Lane

The other thing I will point out, again, and perhaps ask Hans and/or Ricky to comment quickly, is you specified that this is not yet profiled in US Core and that it's in flight and not fully supported in CCDA. So, I think us throwing our weight behind this puts us at some risk that it will not succeed if the standards are not there to support it.

### Hans Buitendijk

It depends on which part we're looking at. So, if we look and say we can use existing problems diagnosis and we just need to clarify which codes we're looking at and our goals that would be one thing. If you're looking at consent, in CCDA, that's not quite there necessarily to the extent of interest. So, I think it's a mixed bag on what's there. And Gravity, as Mark also said, it's in flight. They're working hard on it to get that done, which then would provide the appropriate guidance to move forward with that but it's not there yet. It's not finished.

### Steven Lane

Okay. And I will take us to public comment now and just say that I will endeavor to collapse the various submissions around this item into a single row between now and our next meeting and, hopefully, have time to do that for a number of these duplicates. Public comment.

## Public Comment (01:23:46)

### Michael Berry

Operator, can you please open the public comment line?

### Operator

Yes. If you would like to make a comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 if you would like to remove your line from the

cue. And for participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. One moment while we poll for comments.

**Michael Berry**

And while we're waiting, I'll just note that we are meeting next week. The task force will meet starting at 10:30 a.m. I think it's a little bit shorter meeting next week. And also, I'll plug our ONC annual meeting is next Monday and Tuesday. It's going to be held virtual of course. It's going to start right about from noon until 5:00 p.m. The agenda is on the website. And if you haven't already registered and would like to register, you could just search ONC annual meeting and it will pull up and you can register on our website. Operator, do we have any comments?

**Operator**

There are no comments at this time.

**Michael Berry**

Thank you. Steven?

**Steven Lane**

Very good. All right. So, let's just pause for a second and remind ourselves that we are going to be presenting our work to the HITAC on Thursday, April 13. So, what that leaves us with is really two more weeks to do the work, which is why we re-introduced a shortened meeting next week. So, we will meet on the 30th and the 6th. I think by the 13th, two days prior to the HITAC presentation, we will likely – I don't know. Mike, will we have to have turned in our slides before the 13th or can we turn them in at the end of the day on the 13th for the HITAC on the 15th?

**Michael Berry**

Yeah. That would be fine. We just have to send them out prior to the meeting so we, actually, have until the following day, Wednesday if you need it.

**Steven Lane**

Perfect. Okay. So, we have three more meetings to come to consensus and conclusion on this work. When we have our task force co-chairs debrief later today or later this week, whenever it is, we will start to think about the format for our presentation and our recommendations. Usually, those recommendations come forward as a prose report in addition to a presentation in slide format. So, we'll be working on that over the next few weeks and, again, trying to come to conclusion on these submissions. As I said, I think that there is some more work that the co-chairs need to do. I had hoped that people, as they were making submissions, would find the same data elements that other people had recommended and add their comments to those. But I don't think that quite happened. So, I know everybody is pressed for time and that's a higher bar. So, Leslie and I will attempt to do some of that work to, basically, collapse our recommendations around the given data element together so that we can go through them in a more organized manner.

Leslie, do you want to add to that at all?

**Leslie Kelly Hall**

No. Only if the centers that I have indicated in the justification are inaccurate, please change those as well. And other than that, thank you.

**Steven Lane**

Thank you all for your time and attention. We will look forward to a one hour meeting next week and hope that all of you who have an interest will join the ONC meeting. It's an amazing agenda that the team has put together and a lot that will inform our appreciation for what the ONC is trying to accomplish so that we can support that in every way we can. Have a wonderful day.

**Adjourn (01:27:48)**