



Transcript

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

April 6, 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

Thank you. Good morning everyone and welcome to the USCDI task force. I am Mike Berry. I'm with ONC. I really appreciate you joining us today. I'm going to open up today's meeting and call role starting with our co-chairs, Steven Lane.

Steven Lane

Good morning.

Michael Berry

Leslie Kelly Hall.

Leslie Kelly Hall

Hello, everyone.

Michael Berry

Ricky Bloomfield.

Ricky Bloomfield

Good morning.

Michael Berry

Hans Buitendijk.

Hans Buitendijk

Good morning.

Michael Berry

Grace Cordovano.

Grace Cordovano

Good morning.

Michael Berry

Jim Jirjis. Ken Kawamoto. John Kilbourne.

John Kilbourne

John Kilbourne here.

Michael Berry

Leslie Lenert. Clem McDonald. Aaron Miri. Brett Oliver told me he is not able to join us today, but he'll be back next week. Mark Savage.

Mark Savage

Good morning.

Michael Berry

Michelle Schreiber

Michelle Schreiber





Good morning.

Michael Berry
Sasha TerMaat

Sasha TerMaat
Good morning.

Michael Berry
Andy Truscott.

Andy Truscott
Present and good morning.

Michael Berry
Sheryl Turney. Dan Vreeman.

Dan Vreeman
Good morning.

Michael Berry
Denise Webb.

Denise Webb
Good morning.

Michael Berry
Good morning, everybody. Thank you so much. I will turn it over to our co-chairs, Steven and Leslie.

Finalize Tasks 1c Recommendations (00:01:29)

Steven Lane

Thank you so much. Good morning, everyone. Welcome to our final working meeting prior to us finalizing the content of our recommendations back to HITAC which we hope to get finalized into some documentation later this week and distributed to the HITAC members. I really appreciate everyone coming. Hopefully you have your rollerblades on, and we can slide through some of the material that we have been working on. In the homework we did invite you to highlight any specific items that you had not gotten to that we want to be sure we get to. So, I hope we can do that today. We do have a number of follow-ups from our prior meetings that we are going to dive into.

AI, if you want to go ahead and bring up the member recommendations, the editable spreadsheet so we have got that handy, that would be great. But again, we are focusing on finalizing our 1C recommendations and getting things together for the HITAC. We have started in on the letter to the HITAC, and so we will ask either AI or Mike to walk us through how that is being organized. Then we will have that. Again, it needs to be distributed later this week. So, we will distribute those materials also to all of you. We will accept feedback about that when we meet next week. And who knows, maybe next week will be a short meeting. We probably will have some time to at least modify our voiceover but probably not the materials themselves. Having said that, there were a number of specific follow-up items that we had left over from last time. I made a list of them to make sure that we covered them. There was a lively email discussion about the Medicare beneficiary identifiers, the MBI, that we had been discussing. I had hoped that Hans or Sasha could provide a little bit of meat around that. Hans, are you comfortable summarizing the discussion or would you rather I do that?

Hans Buitendijk





If you want to start with summarizing.

Steven Lane

That is fine. I pulled out what I thought were the key points in the email thread. One is that in FHIR, the appropriate place to use the MBI, it seems to be as the subscriber ID within the coverage resource. So, we were just clarifying where that would be if indeed that were required. If we were to include this in V2, if we were to recommend it and ONC were to include it in V2, it would be the beginning of the use of the health insurance data class which is currently in Level 2. I know that we have had a lot of discussion both from the CMS perspective and from other perspectives suggesting that bringing information about health insurance could be valuable, but that would be a change clearly from what is in the draft V2. The coverage is not specifically called out in US Core though, as I said, it does have a place. There is a clear place where the MBI would seem to go within FHIR.

This is called out clearly within the Karen Blue Button implementation guide, which the CMS interoperability role points to as a suggested path. That guide provides a profile for coverage which includes both an identifier and a subscriber ID. But really this implementation guide is primarily relevant to payers. Again, there are places to put this data. There are implementation guides that point to it. Thus far, I believe, and AI correct me if I am wrong, The ONC has not inserted the health insurance data class into the draft US CDI. But we wanted to finish our discussion and recommendation about this and decide whether in fact we felt that it was important to recommend including the MBI and potentially other insurance ID numbers. There was also the whole question about whether the MBI was really a unique healthcare identifier. I don't think it is, but I know a number of folks said maybe it is. I think AI, you were going to go back and double check with the ONC folks on that. AI, do you want to comment on that before I ask Hans to jump in?

AI Taylor

Sure, thanks. There are two parts to it. I think that suggesting that the MBI or any subscriber information go into a health insurance data class, I think that is fine, as opposed to a patient demographic. That part is fine. I had asked the question of several people who are familiar with the discussions around unique patient identifiers. I did not get an answer back. But I do think because Medicare insurance is an insurance number, it is not a patient identifier, it's more equivalent to the subscriber ID or subscriber number. So, I think that makes sense. I am pretty sure that that's where it would be okay to consider that as an insurance ID rather than a patient ID.

Steven Lane

Okay. So, Hans, again, you were sort of central to this discussion along with Ricky. Do you want comment?

Hans Buitendijk

No, I think you summarized it well. That also means that since US court does not have profiles, but a blue button, Karen does. Which typically for a payer, there is a question of what does the work require to pick it up? In the CCDA, there is a potential place for it, as well, but that would have to be further clarified, as well since it is not in testing, certification, or otherwise. There is some work there to be done as well. That raises the question of not that this is not an appropriate progression. It is completely part of **[inaudible] [00:08:35]**, it's on the path for the objectives set out. Is there an appropriate next step for 2021, USDI V2? Or is this more of a next step discussion which raises the larger question for things like this, would it help that we start to send this as part of USDI V3 discussion, that we more clearly indicate this is what we would really like to put in there, so then at that point in time, their respective guidance can be worked on, any variances can be clarified, and initial update can start to occur to make sure by the time we get to this, we know where it goes as opposed to standards catching up and having only a month or two to catch up with it, a month or two to be considered for ASRAP and then it goes in there. Is that the right approach? So, that would be for me more of a question. Is this the right timing or is this something that we really need to pick up in our next circle for USCDI V3?

Steven Lane





Are you simply presenting that as a question, Hans? Or would you like to state your preference? I think I hear it in your words, but I'll put it out there.

Hans Buitendijk

Yes, I think this will be a good example of something that there is no debate that we need it, but that in light of the guidance available that this would be a candidate for V3 very early in learning and indicating that this is the direction that we are heading and then we can start to prepare for it.

Leslie Kelly Hall

We have comments from Clem and then also Mark has a point, and Sasha has a point in the chat they might want to articulate. Clem?

Clement McDonald

Two things. One of them is I think we have gotten all tangled up in the conclusion about a unique identifier being forbidden to be created. I don't think that has any bearing on this because it's not anything that is being created. That is what the law says, we can't create a unique patient identifier for all patients. On the other side of it, I think it will be much more useful in the patient record than in the insurance record. It doesn't get carried around with everything, if you want to linkages and all the rest. The patient record allows for multiple identifiers and FHIR and V2 both have a way to distinguish which identifier is which. Forget the whole issue about unique identifiers because it isn't what the law prohibited. It is just an identifier which happens to come from the insurance carrier.

Steven Lane

I think we have settled on that. I think everyone agrees that the insurance ID is not a unique patient identifier. Go ahead.

Leslie Kelly Hall

Mark, did you want to expand on your comment?

Mark Savage

Sure. We are talking about the beneficiary number. I just wanted to flag that App and others have recommended the health insurance data class. So, I'm just making sure we are focusing on the broad recommendation as well as this particular recommendation. I hear the comments about state of play. I have talked to the folks at UCSF. This is obviously important. It is important for value-based care, making sure people are getting coverage in-network. It has been around for a while. I understand the comment about sort of waiting for V3. But we have been waiting a long time.

Leslie Kelly Hall

Are there other comments? I didn't see hands raised. Are there other comments about this? I think, Hans, I have a question for you. And Michelle also has her hand up. So, before I get to my comment, let's get Michelle's comment.

Michelle Schreiber

Hi, thank you. Tracking patients and being able to see their insurance class and having an insurance identifier, we think is actually very important, as Mark points out. How patients get care, how they are in certain networks, how they are not is really important for how we are directing patients these days. While we would certainly understand if it had to wait until V3, we are the same people who said we took it off because we wanted to have further conversations and evaluate it, we really do think it is important. And if there is some reasonable way to get it in at this point, we would be very appreciative.

Leslie Kelly Hall

Thank you. I would like to offer a comment too, Steven, about Mark's and just the data class. Of any item that is collected, this is collected, the insurance information is collected prior to entry of service. It has been a requirement, although perhaps not stated, when you present to any level of service, you are asked for





your insurance information or whether you have insurance information. So, the maturity could not be greater than this. I would advocate that as a piecemeal approach to this is more difficult than just taking the whole class forward. So, we can't argue maturity. We can't argue against exchange. We all have to do it. So, that would be my comment.

Steven Lane

So, let's try to bring this to a close. I have tried to capture some notes here that the MBI would best fit within the health insurance data class, member identifier data element. This is not a unique patient identifier. It is prohibited by current federal law. Hans is suggesting perhaps waiting until V3. We have got a few people suggesting that it move ahead. Does anybody want to weigh in one way or the other?

Clement McDonald

I would back Leslie's position. Forget my little detailed discussion.

Steven Lane

Yes, I have got you down. You are for. Is anybody else against? Does anybody else think we would be better off not recommending this to go forward?

Sasha TerMaat

I don't think we should recommend using the FHIR standards to convey this information against the current implementation guides. I think we need to make the US Core work for coverage a prerequisite to include this in the USCDI. In essence, I am not against including it in USCDI, to be clear. I think it is important and we ought to work to include it in USCDI. But I do think we need standards work as a prerequisite.

Steven Lane

Does that suggest, Sasha, that we don't have time to do it now?

Sasha TerMaat

I think the standard development organizations would have to estimate how much time would be necessary to include in US Core. I suspect it would not fit into these two, but I would defer to HL7 as far as how long they think that work would take. Karen implementation guide would certainly give us a starting point for US Core.

Steven Lane

Go ahead, Hans.

Hans Buitendijk

If I may add to that from a timeline perspective, SVAP 2021 is later this year and we will look at when is USCDI Version 2 sufficiently clear that it is in or out and look at the timing between them. And an update to US Core would require for something like that another ballot round. Do we think that that can all be put in time in that timeline? Or do we say this is a good lesson learned that we really need to start to look at things further ahead so that the necessary standards developments implementation guidance work can occur so that it flows and can be validated and then move forward? It is not that it is not necessary data. It is not that it is being used in Version 2 or on claims. But is the appropriate guidance and CCDA and US Core available as the main implementors of USCDI V 2 or USCDI for access and context for in-depth context? That is a little bit more where I think the concern is, not with the importance.

Steven Lane

Clem, do you have another comment?

Clement McDonald

USCDI is not bound at the hip to a prior [inaudible] [00:17:45]. It is for all of them. And if V2 already supports it, which is the predominant communicator of who the patient is and where the patient is, I say let's stop dragging our feet.





Steven Lane

I'm going to pause this here and say that I think we are at a classic conundrum for us. Which is to say that there are data elements that are well defined and there are data elements that are not well defined. We have talked to AI and he has told us it is okay to put in things that are not super well defined and the SVAP does give the vendors sometime to get these sorted out. I guess the real question is just does including something that we are hearing from the two major vendors may present a challenge, is that wise for us, really is my question. I think what we want is to make recommendations that it will be acceptable, sort of lock stock and barrel. And if this one sort of steps over that line, I am not sure it is in our or the community's best interest to push the envelope in that way. I'm curious what others think.

Leslie Kelly Hall

Ken, do you have a comment?

Ken Kawamoto

Yes, thanks, Leslie. I think my comments, Steve, is around it is not well defined. The recommendation is ONC requested it becomes better defined and request of HL7 and the accelerators that they provide some precision in this particular area. I think that is a very straightforward and easy recommendation to push upwards. I don't think it could be a barrier for our recommendations. It should be included. Put it that way.

Leslie Kelly Hall

Right. If we add one thing, we can add anything. Go ahead, Mark.

Mark Savage

To your question, Steven, this would not be the first time that policy has helped move to the ecosystem faster, and it should.

Steven Lane

Okay. All right, so I certainly hear the preponderance of voices supporting this. Does anyone want to die on this hill? Either Hans or Sasha, do you guys want to stand up and say I don't support this? Or do you feel comfortable if we recommend including health insurance data class and member identifier data elements in V2?

Sasha TerMaat

To be clear, we are going to recommend doing this even though we don't have a US Core implementation guide for coverages yet?

Steven Lane

That would be the case.

Sasha TerMaat

I think we should make having a US Core implementation guide a prerequisite to inclusion in USCDI, personally.

Steven Lane

Comments?

Hans Buitendijk

I was going to go in the same direction. If we adopt it, FHIR, US Core and CCA need to update the guidance in order to reflect that and that not available before SVAP 2021 is being issued that would include USCDI Version 2. Take that assumption for a moment. What would that mean? I hear Clem on HO73. That one is relevant. It is all about CCDA and the US Core needing be able to support, particularly, FHIR. US Core needing to be able to support USCDI and then they would be out of sync. How would that work? That, I think, is the concern. The timeline, is that enough to get everything up to date to support that in time? That





when SVAP comes around, it actually can point to a more current version of the implementation guide that supports USCDI version 2. Or if it does not support that, what does that mean? If the latest implementation guides do not explicitly and properly include them, what does that mean? Again, I am not worried about version 2 because that is not the one we are worried about.

Andrew Truscott

So, Hans, isn't the purpose of this group to shine a light upon that discrepancy? To shine a light and request that it is resolved and as it is resolved, that it be adopted?

Hans Buitendijk

Generally, conceptually, I completely agree, hence my earlier comments. If we believe that in the timeline that we have available by SVAP for 2021, this year, this would be a challenge to do, we need to start to use a V3 or V4, not for this one, V4. For V3, the burden after that to be able to say this is what is on our line, this is the sequence in which we are thinking about it, so those standards can be leveled up to be in sync with the most likely next version of USCDI is going to be. So, that they can be synchronous at that point in time.

I'm going to go back to the comment that AI made in the earlier discussions is that when you are going to adopt, voluntarily us USCDI Version 2 or version N in an ASRAP, that means you are adopting all of USCDI Version N. If your standards and implementation guides have not been leveled up to reflect that because of the time window that was available between USCDI Version N being published and finalized that we can look at that and everything else falls in place with background perhaps needed to do that. Have we created the situation where that is going to be very difficult to do or not as intended to be done? That is the issue I am raising on aligning the flow of how we ratchet these standards up. Again, I want to be very clear, not a priority issue or an importance issue. It is are we setting ourselves up by defect of using USDI Version 2 is moving at a certain pace and are the other ones going to be ready in time to support that given what they have to go through to be ready?

Steven Lane

I think we need to cut this off. We can't spend all of our time on this one. We do not have consensus on this. And I am a big believer in consensus decision making. I suggest that we set this aside from our recommendations based on the concerns from the major vendors and the people who are expert in leading things through to the development on the vender side. And I would like to leave apologies to those of you who feel we are being wimps. But I think we have to move on.

Andrew Truscott

Okay. I disagree with that, Steve. I think this could be addressed very quickly. If Hans and Sasha could actually provide the clear statement of what they think we should be saying and then we can elect to include that or not.

Steven Lane

Okay, but I don't want to spend the rest of our meeting on this.

Andrew Truscott

I agree on that entirely. But, Hans, what do you suggest we do?

Hans Buitendijk

I thought that Sasha summarized it well in that we can recommend it with the provision that the standards are ready. That will force the question can it be ready. You heard my concern.

Andrew Truscott

I heard your concern. I'm sorry to interrupt. I heard your concerns completely. Is our recommendation that it should be included provided, I like the proviso, and that we recommend that ONC request HL7 to advance the ball down the court and leave it at that?





Hans Buitendijk

Yes, perfect.

Andrew Truscott

So, don't take it away, Steve.

Denise Webb

This is Denise. I agree.

Steven Lane

So, we are recommending for inclusion in V2 with the provision that HL7 provide what by when?

Sasha TerMaat

I think we want a validated US Core implementation guide for coverages prior to inclusion in USCDI. If that can happen in time for V2, then that is great. Otherwise, if that doesn't happen, it would be included in the next version of USCDI.

Hans Buitendijk

Exactly right.

Leslie Kelly Hall

And this is for the entire board approval, correct?

Steven Lane

Got it. All right, I have got the recommendation. Thank you so much. I don't mean to be a beast, but we have got to keep moving. Hans also helped us dig into encounter disposition and provided some details on that. So, if we can go to that row. Which row is that, guys? Did you find it, AI? We still, unfortunately, have not beaten all of the duplicates out of this.

AI Taylor

What was the data element again?

Steven Lane

Encounter disposition.

AI Taylor

It might be six.

Steven Lane

It is six. That is not where I put my notes. So, let me pull up the notes from Hans earlier. So, Hans, you were asked last week to double check this information with regard to CCDA. And you did that. I will grab that and put it in this row, also. Do you want to comment on this? Encounter disposition that was also a CMS request? Okay, here I just added it in the spreadsheet. So, if you just refresh, AI, you should be able to pull that up.

Hans, do you want me to read it? You said CCDA references that this should be selected from a specific value set. The HL7 discharge disposition resolves to a specific list which you included. The US Core also has a specific reference and some mapping would have to be agreed to, which I'm not sure has been done. However, since the US Core has this as an example binding, one could argue that aligning it with CCDA would be reasonable. So, this is about the initial request from CMS to include encounter disposition and again specifically we were talking about a limited set of dispositions from hospital and ED encounters including short stays and that we would signal this should be included for long-term care facilities when that is possible.





Hans Buitendijk

Yes. The fact that the CCDA already has more clear guidance as what to include whereas the US Core is more exemplar, the values are not exactly the same, but the concepts are across both. It is not a full set. I think this is one that is much easier resolved in terms of finding the right data set that US Core should support then as well when we include this since CCDA is already accommodating it, where the data is going.

Steven Lane

Thank you so much for doing that. We had previously set this as a recommendation to include in V2. I think this just bolsters that suggestion. Does anyone feel otherwise? All right. Thank you so much for that, Hans, for doing that homework.

The other notes that I had that we wanted to come back to, Clem was kind enough to post on the public website some further information around diagnostic studies and exams pointing the ONC to listing white panels that support a various non-lab clinical reports. So I won't go through the details of that but that is there for everybody. Which row are we on with the diagnostic studies and exams? The other thing was, Clem, you had been talking about tonometry and I actually did a little bit more digging and I found tonometry, but it is Level 1 I think, or comment level. It is not Level 2. So, that would not be included. That is outside of our scope.

So we are on row 29. So intraocular pressure left and right were submitted through the on deck. They were specified by ONC as a Level 1 data element. So, they are out of scope for our test, 1C, as much as I know you have been advocating for that. I would suggest that on row 29, we are modifying our recommendation to recommend inclusion of colonoscopy, echocardiograms including left ventricular injection fractions and PFTs. It wasn't clear to me from our discussion whether we were also recommending inclusion of ECGs. I know the echo cardiogram left ventricular injection fraction was the key thing that Michelle had brought up. Obviously ECGs are incredibly important to clinical-care, the interpretation, and I don't think we are talking about the wave form image here, I had an open question about that. So again, my proposal, we are striking eye pressure. We're not recommending that. It's out of scope for us. But ECG could potentially be included along with echocardiogram PFTs and colonoscopy. Thoughts?

Leslie Kelly Hall

Clem has a comment. Clem? You are on mute, Clem.

Clement McDonald

I forgot my mute. So, the earliest position in this group was we should do diagnostic studies at large without narrowing it down. We should not have restricted it to just labs. Remember, the very first proposal we were cheated in as a lab test, all diagnostic studies. I don't think that is right, but it would be nice. The other position was, and it came from CMS, is we should broaden and bring all the diagnostic studies. This was a small list. And tonometry counts as a diagnostic study. I am pretty sure the National Institute of Eye proposed it. I don't know what makes it one or two, but it seems like one is better than two, not worse. And it is so easy. It is just so easy.

Steven Lane

Clem, I'm sorry, but it is out of scope. We just can't talk about it. It is not what we are here to talk about. I am with you. I want to do the easy stuff too, but ONC made the determination that it was Level 1. So, we can't touch it.

Clement McDonald

Just clarify, is one worse than two?

Steven Lane

One is less ready for exchange than two. But again, we are not here to clarify that.





Clement McDonald

Okay.

Steven Lane

We can do that next week. So, my question is ECGs, does anyone feel one way or the other? I would love to include if there is not some other technical reason why it cannot be included. AI, do you have an opinion?

AI Taylor

I haven't really looked at ECG in particular, but I will say that I think it would be more productive to focus on the concept of the data diagnostic studies either as a data class or a data element, which could be more inclusive as a data element because when we have seen lacking clarity about exactly which studies ought to be included or what elements ought to be included in a data class, we either don't included or we are less specific about it. So this is equivalent to saying laboratories as opposed to saying hematology labs and chemistry labs and micro labs. We simply said labs. I think that looking more general rather than looking more specific. The issue about which tests to include, I think are more relevant for a discussion about how testing and certification is done. So, what sort of codes or what sort of studies are included in the test data per certification. I don't necessarily think that we need to get into the specific tests that ought to be included.

Steven Lane

My recollection, and John we will catch you next, is that CMS had specific tests that they were interested in to support quality measures. They happen to include a couple of imaging studies, mammo and deixis. So, we took those out. It left us with a few specific non-lab tests, colo, echo, PFTs, that were in that intersection of quality measures and diagnostic studies and exams. So, I think we were simply recommending that this be included, diagnostic studies and exams with results be included in V2 and that there be specific examples that should be included in testing certification, including those that CMS wanted. That is where we are at is in the specific examples. John, your comments?

John Kilbourne

Just real quick. I agree. I like the idea of chunking up more than doing onesie or twosies. But I understand the onesie, twosies approach has utility related to quality measures. And then with the EKG, just do you have to be specific about you want the interpretation and not the wave form? And if you do have to be specific or clear, then we should be clear. Will people get confused if they have to send the wave form versus the text interpretation. We just want to be sure we don't make confusion around that.

Steven Lane

Totally agree. Ricky?

Ricky Bloomfield

Yes, I just wanted to make the comment that the comment here that there is no specific observation profile except for this listed is true. But also, I think that at least for US Core, this could use the diagnostic report guidance around clinical notes which specifically describes cardiology as well as radiology and pathology. So, I think this could potentially fall under the cardiology report and could easily be mapped to that a simple text-based report of the ECG results. I just wanted to highlight that there is another avenue if you wanted to include this.

Leslie Kelly Hall

Sasha is mentioning, as well as I know I am confused, are we talking about the whole class in a general recommendation as AI spoke to? Or are we speaking only to those items in the example here?

Steven Lane

I think the recommendation as I am envisioning it is that we recommend inclusion of the element, the data class, diagnostic studies, and exams with results. And that we are suggesting a short list of specific studies to be included in testing and certification.





Leslie Kelly Hall

Clem has a comment, as well. And then I think we need to bring up a screen.

Clement McDonald

Yes, just to clarify, 12-lead EKG is the focus. And there are about eight or 10 variables that are reported on every 12-lead EKG, the measurements, PR interval, PRS interval, etc. There is usually a little interpretation as well. That is what we should be testing against. It has been standardized. This one big company does almost all of them. They have a standard percent for this stuff for 20 years. And it was perfect, it was V2.

Steven Lane

Okay. So, we have a recommendation in cell 29L. It says, again, final time, include diagnostic study, data class in V2 with specific examples of studies that should be included as part of testing and certification, including colo, echoes with left ventricular injection faction, PFTs, and ECG. And of course, there will be details. We specifically say not to include the wave form. All right? Going once, going twice, gone. Wonderful. Thank you all. And I apologize for pushing this so hard.

The last one was I just wanted to mention to people that Pew posted comments a couple of days ago on the First about ISCDI specifically encouraging use of U.S. Postal Service address standard for the address, including all data elements needed for public health reporting as part of V2, whatever that means, and accelerating inclusion of social determinants of health, which we have certainly discussed here. I just wanted to bring people's attention to those public comments that were submitted. All right, let's go back.

Leslie Kelly Hall

Steven, Adobe just crashed on me. So, someone else is going to have to –

Steven Lane

Yes, it is acting odd. Michelle, you had your hand up, I believe?

Michelle Schreiber

I did, thanks. I don't know if this is the right time to circle back from this but the conversation around SNOMED and ICD 10 and the problem with the VA. I know they wanted to make sure they circled back to us and would like to make sure that we always have SNOMED for problems list and that ICD is optional. So, I wanted to bring that to the committee's attention. CMS is okay with that. But I wanted to make sure the committee was too. And I know John Kilbourne is on. So, I don't know if you want to speak for the VA. This was your guys' request.

John Kilbourne

Right. We had a powwow on our end going up the team. It is very important to VA that SNOMED be definitely include. And ICD can come along for the ride, so to speak. As Michelle is happy with that, which it sounds like she is, we come to you with a combined voice between the CMS and the VA asking that SNOMED be mandatory on the problem list and ICD can also be included as well.

Steven Lane

All right. I think that is consistent with our recommendation. I apologize that we don't have our spreadsheet as organized as I would like. But I think our recommendation was simply to allow ICD, in addition to SNOMED. There was discussion about potentially someday deep-sixing SNOMED because it was felt to be archaic. But I don't think that that is our role at this point. So, that was part of the comment. Can anyone help me find this so we can make sure we have our recommendation straight? There we go, encounter diagnosis. It is row 32. Our recommendation currently reads, "Recommend leveraging coded billing diagnosis." I think this is the one where we have these notes.

Clement McDonald





I thought we were requiring both.

John Kilbourne

This is for problem or encounter diagnosis.

Steven Lane

We are talking about counter diagnosis. I think problem list was already covered. Here we go. No, it is row 35. This was for problems. CMS recommended adding terminology to problem data class in V2, adding ICD-10. And we ended up with our recommendation on row 35 saying, "Suggest that ICD-10 be added as an allowable standard for coding of problem list diagnosis. That is where we ended up after all that discussion. So, I don't think that what you are saying, John, is any different. Clem, your hand is up?"

Clement McDonald

No, never mind.

Steven Lane

Okay. So, are we good with that? Allowable. Okay, perfect. Thank you. Other things that we had flagged for follow-up was Grace's recommendation, 1T recommendation about allergies and intolerances, specifically substance medication. And this was suggested actually simplify data organization hierarchy. We never got to this. This is about medication. I think, Grace, your comment was, let me see what was your comment? Do you remember this?

Grace Cordovano

Yes. We did address it.

Steven Lane

I'm sorry?

Grace Cordovano

We did address it. And I thought the conversation was that it could be further simplified, that everything had to be called out.

Steven Lane

Okay. That is my recollection as well. I think we want to keep medications and non-medications separate because many systems do that. I think clinically it makes sense. I just wanted to get back to that one. The next row down is the care team members. I have that one flagged for follow-up as well. Let me see what that was. This was Andy's comment about the National Health Service buildout. We did not end up with a recommendation on this one. This is on row four. The recommendation from a number of folks was to align with HL7 provider details, move to USCDI Version 2. So, this is the specifics around care team member details, the number of data elements that were included in Level 2 but not in V2. I do not have a final recommendation on this one. Would someone like to propose one?

Mark Savage

This is Mark. I'll move inclusion.

Steven Lane

Okay, but be more specific. We need to be very clear here.

Mark Savage

I am talking about the data class as in the recommendation on line four.

Steven Lane

So, include the data class care team members and all of those data elements that are coming from Level 2?





Mark Savage

Correct.

Andrew Truscott

I agree.

Hans Buitendijk

Provider or other care team members as well to the extent that they have the information?

Steven Lane

That was clear in our discussion.

Clement McDonald

Be careful, the DEA, that's going to be available for lots of people.

Steven Lane

Yes, we are clear on that. We totally get that. It's if available. Anything else on that? No objections? All right, good. I captured that. Thank you. I will un-highlight that, so I know where I am going.

Andrew Truscott

We were very quick just for you.

Steven Lane

I appreciate it. I do. I also have a flag on row 15. This had to do with medication, data class, discharge medication, data elements. We had a discussion where we recommended the addition of discharge medications to enhance the medication data class that is currently in V1. This content is represented in FHIR resource medication requests category. Are we, as a group, comfortable pushing this one into our recommendations for Version 2? Discharge medications? Any concerns one way or the other?

Sasha TerMaat

I have a question regarding that. Is that going to flag which medications are active or discontinued? Can we clarify what that means?

Steven Lane

Again, the data elements of discharge medications is in Level 2, just to be clear. Our role is to say to include it or not.

Clement McDonald

But just to be clear, they are medications that people are taking on the way out, the ones they are giving them to take. So, I don't think there is a question about active or inactive.

Steven Lane

Yes. We discussed this as a flag on the medication list. Again, the specific recommendation came from CMS, Joel Andress. I don't know if Michelle or anyone else from CMS is prepared to comment on this. There is a lot of detail in this, including use case project page, a number of applicable standards, specifications. There is a lot of thought that went into this. Our question is do we suggest promoting discharge medications to Version 2?

Sasha TerMaat

Sorry to ask another clarifying question. I would assume discharge medications are already a part of the medications USDI class. Is the concern that we want to specifically identify them as the prescription placed on discharge? Or just that somewhere I misunderstood, and they were not previously included?





Steven Lane

My understanding is that this would be flagging those meds on the med list as a discharge medication. And we have heard a number of use cases as to how that would be used. But again, this is one of those the system should capture, obviously it is an inpatient system, that a medication is flagged as a discharge medication. Then it should send that data with requests for access exchange.

Leslie Kelly Hall

Michelle has a comment as well. Michelle?

Michelle Schreiber

Actually, I think Steven summed it up really very nicely. One of the staff, Joanne, is on the public line if you want further detail on this. But I think you captured it, Steven.

Steven Lane

Thank you. Are you comfortable with that, Sasha?

Sasha TerMaat

Is that decision part of US Core today? I think the discharge medications would be included in a CPA, in FHIR ATI call for meds. I'm just not sure that there's a distinction of which ones are prescriptions placed at discharge versus other prescriptions or medications. We can take it as a follow-up, but I don't know offhand.

Leslie Kelly Hall

Hans did talk about the security filter, which is currently not marked, and it might be supported. But there is enough of a compelling use case, I think we would seek to have this recommendation go forward.

Hans Buitendijk

I guess just a general comment is going to come whether it is coverage, whether it is diagnostic studies, generally what are the standards, the implementation guide. It is not the standard that supports it. It is where the implementation guide is not sufficiently up to speed and needs work and needs piloting. There is just a risk that the standards will be too late and that has a risk. As long as that is understood and we make the same comment on these that is so important, that we recognize that there is still maybe some work to be done, in particularly these ones, we can put them in. But there is the risk that relevant and critical standards are going to be behind the curve to get up to speed in the timeline of USCDI Version 2 is up to date.

Steven Lane

So, should we footnote this one as we did the one earlier to say that this would be contingent upon HL7 providing the relevant standards and implementation guides?

Hans Buitendijk

It is really the implementation guides that matter. It is not the standard. The standard is fine.

Sasha TerMaat

I wonder if we should actually make that globally as a recommendation because Hans and I were discussing, I think it is true for the diagnostic studies that we were discussing also. I think in general we want HL7 to use the recommendations this task force comes up with to prioritize their work and know that these are industry priorities that we want incorporated in CCDA in US Core. So, maybe sort of even broadening beyond these two data classes or those three to say we want ONC and HL7 to direct industry standards development work around some of these things that are identified as priorities so that we can implement them in an efficient way now that they have been identified that way.

Steven Lane

Can I ask Andy to comment on that as the chair elect of HL7? Do you support that approach?

Andrew Truscott





I was really, really hoping you weren't going to call on me at this point. I think that is the right approach. I think there is a bunch of application work going on inside HL7 right now which this would actually fit very neatly into. I agree with where Sasha's coming from. Someone made the comment that this isn't about standards, this is about implementation guides when it comes to FHIR. And it is about updating US Core and elsewhere. So, essentially, I agree. I would ask that this task force request that the HITAC, actually formally write to HL7 and ask this rather than just anecdotal word of mouth.

Leslie Kelly Hall

Grace had a comment.

Andrew Truscott

Was that an agreement, by the way? That this task force will recommend HITAC write to HL7?

Steven Lane

I am going to add that to the recommendation field.

Andrew Truscott

Thank you. Michael can tell us whether this task force can actually write to HL7 directly. I don't know whether that is apt or not.

Leslie Kelly Hall

So, we have a comment from Grace who has been waiting a bit and then Hans. So, Grace?

Grace Cordovano

I want to follow up on my previous comments. So, I agree with the discharge medication, but at the time that patients are discharged, they are often discharged, their paperwork states medications that they are not taking. And there is no way to edit this. So, I don't know if in this recommendation if we have any power to make a comment that we are discharging patients frequently with medications that they are no longer taking. I don't know how this helps that situation.

Steven Lane

I would argue, Grace, that that is an issue that needs to be addressed by the receiving provider as they reconcile the discharge instructions. I think that the point here is simply to flag those medications that were indeed prescribed at the time of discharge, which often does not include meds that the patient was on when they went into the hospital. So, it is really helpful to know that when you are receiving the patient afterwards. Hans?

Hans Buitendijk

I just want for your notes, Steven, as a parking lot for the next topic that we really need to talk not just about Version 3 but if three and four, if we can somehow phase, bucket, prioritize things in the notes that are going to go to HL7, in particular. That would be tremendously helpful if there is an outline in the not too distant future as to what are the four, five, six, whatever it is on either one of those lists so they can start to plot it out. It is looking forward one or two versions ahead that is really going to be critical to make this a nice smooth train.

Steven Lane

Okay. We will figure out how to capture that. Anything else on discharge medications? All right. I have a flag down on row 25 where we were talking about orders and specifically types of orders for medical care and services. And CMS was recommending inclusion of end-of-life orders in V2 and we all sure appreciate the value of those. We said that this would include, I tried to capture this in the discussion, would include orders for palliative care, hospice, comfort care, DNR, DNI. And the question was raised as to whether this would include POLST and MOLST orders. And we felt that yes, those are the orders in the same category. Would this include then directives? And that would be a no because those are not orders. Those are other items. To be clear, advanced directives are well specified as a Level 1 item. There was a lot of detail





submitted for advanced directives by Matt Elrod from ADVault. I gather that is an advanced directives application vendor. So advanced directives are off the table because they are a Level 1. But a number of these items do fit within the category of orders for medical care and services. So, any further discussion, it would be nice to get to a conclusion on this one.

Leslie Kelly Hall

I brought up the advanced directives, Steven. Because are there unintended consequences when we just have the medical ordinances [Inaudible] [00:59:19] without the patient's voice, which is really in the advanced directive? So, does there need to be alignment with those? Can you go with one without the other when in fact the POLST and MOLST are really the medical version of the advanced directive. I realize they are Level 1. I wondered how we set the signal for alignment of advanced electives and orders.

Steven Lane

Clem, your hand is up?

Clement McDonald

Yes. I am supportive emotionally with the advanced directive idea. But they do not flow in the same channels. It is a tough problem because there are systems that keep central records of them. Patients may have it in their purse. It isn't channeled in the ways you can capture them reliably. So, I think it is a good thread. But I don't think it can be easily done in this timeframe.

Steven Lane

I think advanced directives really don't have a lot of specified data fields. There are different forms that are used in different context. Most of them do include who is your primary, secondary. The bottom line is it is Level 1, it's off the table, it's out of scope, so let's be clear. All we can talk about is orders. I don't mean to be rude just to get our work done. This is specific. The question is should we be recommending inclusion of the data class orders, the data element. Let me just double checked the website to see what this looks like. Types of orders for medical care services, that is the data element that has been leveled as Level II. There are other data elements under orders that are leveled as comment levels, so we are not talking about those. Those where portable medical orders for life sustaining treatment. That is probably the one we are talking about actually. That is a comment level. So, actually that is interesting.

That one looks like it is POLST and MOLST. Yes, that is POLST and MOLST. So, POLST and MOLST are comment level. I don't think we are allowed to include those in our specific recommendations. But what we are allowed to include is the data elements. Sorry, we are allowed to include the data class. No. The data element is types of orders for medical care services. That is the data element under the data class of orders. But the specific data elements of pro-condition instructions for licensing and treatment and POLST, MOLST, those are comment level. So, I don't think we are in scope to specify those, but it looks like we could specify, just to be clear, we can specify the Level 2 data only, types of orders for medical care services. That is as far as we could go. This was submitted by CMS. It is being advocated for by CMS. I think that is the question on the table.

Leslie Kelly Hall

So, Steven, I guess the question is do we wait to have these in alignment at a future level or have these now? My concern is you have DNRs without POLST and MOLST. Are there unintended consequences that can go forward?

Steven Lane

I think you make a really good point, Leslie. Other thoughts? CMS, do you want to weigh in?

Michelle Schreiber

I was just raising my hand. I understand the problems of maybe unintended consequences of having DNR orders that are being transmitted. On the other hand, it does at least give you a history that DNR has been asked or ordered on a patient in the past. It doesn't mean that that is the order that is standing for the patient





if they get admitted to another facility. But that facility has the ability to see that DNR was ordered in the past and I think will hopefully engage the conversation very quickly about establishing another DNR order if that is appropriate. Palliative care is another one that when ordered I think is extremely important. Selfishly, from a quality measure point of view, we exclude a lot of patients when they are in palliative care, but it is very difficult to tell who is actually in palliative care. I think we still would support having this but understand if the committee thinks this would cause too many unintended consequences, we would at least like to put this really high on the V3 consideration list. I still think it has merit now.

Leslie Kelly Hall.

I would agree with you. Steven, I spoke to the doctors about the unintended consequences without having POLST, and MOLST, and DNR. But as Michelle describes, it seems event based only and not overall arching that maybe a POLST or MOLST or advanced directive would be. So, I agree going forward with some. But I would love to see us include recommendations in our future work with these very high on the list of having synchronization's between any end-of-life care, POLST, MOLST, advanced directive listed here. So, I would recommend going forward as described with that caveat.

Steven Lane

So, describe it one more time just so I can try to capture it as a recommendation.

Leslie Kelly Hall

I would take the first paragraph that is in there to talk about discussions as going forward. And we would consider additional end of life scope for our future work, which would include POLST, MOLST, DNR, advanced directives.

Steven Lane

Okay. So, we are going to take the first paragraph and simply we are going to take out DNR, DNI because those are called out separately as a comment level. Then we will include the rest of them, which is to say we recommend including orders for end-of-life care including palliative care, hospice, and comfort care, essentially.

Leslie Kelly Hall

Correct.

Steven Lane

Anyone object to that? All right. We will include that. I have captured it. I am unflagging it. I think the next yellow we already talked about that. That was encountered diagnosis. We just had that split between a couple of different rows, unfortunately. I think that got us through the yellow. Which brings us with a few minutes to spare to entertain additional high-priority items that people have in mind that we have not yet considered. I actually think we do one or two if there are some that are burning. Mark?

Mark Savage

I may be mistaken, but wasn't the SDOH data element flagged in yellow?

Steven Lane

Still open? Let's see. Thank you. I thought we came to a conclusion on that, that we all agreed.

Mark Savage

If the conclusion was yes to include, I'm fine with that.

Steven Lane

I think there may have still been some open points of discussion, perhaps, that someone was going to be looking into something on that.

Leslie Kelly Hall





I'm looking for the row.

Steven Lane

What is it?

Leslie Kelly Hall

I was just looking for the row for Mark.

Mark Savage

I saw 45 through 49. I don't remember which one was red, which one was yellow. Steven, if it is resolved, we can go forward.

Steven Lane

You are right. We put yellow on 45. Thank you, Mark. Okay. We hadn't come to a final conclusion. I think that would be a wonderful way to finish off our meeting today. So, to be clear, what we are doing is looking at a number of different rows here, all of which fell under the SDOH data class. There are a number of data elements, as we know, that made it to Level 2, assessments, goals, intervention, outcomes, problems/health concerns. CMS recommended including them. Many of us have recommended including them. I think we just need to finish our discussion. There was a lot of applicable standards that were identified. Now, of note, just to help support this, the hard work that Hans and Ricky did identifying where this was included in US core, CTBA showing that we did not have full support there. So, I would think that these probably would end up having that same caveat that we discussed earlier, that they be included as soon as their implementation guides and that we highlight these in our recommendations to HL7, that they put this on the front burner. Would that make sense? I see a number of hands up. Clem, you are up first.

Clement McDonald

I am for what you are talking about. I was on another subject, so I should wait. You said any other things that we had to discuss.

Steven Lane

Oh, okay, sorry. We will come back. Mark, do you want to say more?

Mark Savage

Yes, just to flag the data point that there is an implementation guide in ballots being reconciled right now. I know we have talked about this as a structural approach on some other items. This may be slightly more advanced and different. I am just making sure everybody is aware.

Steven Lane

Are there any of the data elements that were leveled as Level 2 that people have specific concerns about? Or can our recommendation be to include in V2 the data class and all of the elements that were leveled as Level 2?

Hans Buitendijk

The problem here is I agree with Mark, it is that the guide is well on its way, making good progress. It would not quite make it. I think it is interventions that is probably the one that is the more challenging one. The other ones, there is already a lot there, so, I think this is going to be, at least in part, if not in total, has a good probability to make it in time.

Steven Lane

Okay. So, but we do feel that the finalized IGs would be a prerequisite to adding this to USCDI?

Hans Buitendijk





I would agree because they really import on how to value and use the respective resources in FHIR. And that then leads to a question of in CCDAs, is that enough a parallel to work with. And that needs to be discussed. Mark is probably closer to that right now than I would.

Steven Lane

Sasha, do you want to weigh in?

Sasha TerMaat

I agree, the implementation guides are a prerequisite.

Steven Lane

All right. Clem, your hand is up?

Clement McDonald

Well, it is not on the same subject.

Steven Lane

Oh, I'm sorry. Your hand was still up. My apologies. Al, if you could refresh your screen, I pushed the recommendations up to the top. The problem here is that the applicable standards got so long that they are hard to see. So, the recommendation as I captured it simply says include in V2 the SDOH data class and all of the data elements identified as Level 2. Include in the HITAC/ONC letter to HL7 a specific request to prioritize the relevant IGs for finalization as a prerequisite to adding these data elements to USCDI. Did I get that right, Andy?

Andrew Truscott

You did.

Steven Lane

Okay. Look at that, it brings us to 8:45. That applies to all of those SDOHs. So, that yellow is going away. Thank you so much, Mark. All right, now Clem, your hand has dropped. Come back.

Clement McDonald

I don't know which way my hand goes. I have two kind of issues. They are not aligned perfectly. So, one of them is the definition of procedures. FHIR defines a procedure, distinguishes procedures that are diagnostic from those that are therapeutic. So, it is defined as something that is invasive. I think that would be very useful in terms of aligning people's use of the various coding systems and procedures versus observations. I don't know if that is even something worth talking about. It is ambiguous except in FHIR. And FHIR has a good definition. Hans, can you speak to that?

Hans Buitendijk

Not quite yet. I must apologize, I was just looking at another screen to check something out.

Clement McDonald

That is all right. I think that along the line somewhere, it would be useful to not have CBT be the code for glucose, which is kind of a procedure in some sense too. Maybe that is covered by the way the codes are specialized in observation. But every time the discussion comes up, there is confusion. The procedure can be perceived as anything done to a patient. But surgical procedures is really what I think FHIR is talking about. They have a really specific definition.

Hans Buitendijk

It is more the invasive part of it as opposed to the diagnostic procedure that is observation. So, that is the general distinction. If you want, we can get the exact definition.

Clement McDonald





I don't know if we have a pathway to say that here. But I have a second one I'd like to bring up.

Steven Lane

I think we do, actually, Clem. Just to orient us, so procedures are included in the USCDI Version 1. There is nothing new in Version 2. In level 2, there are two new data elements which include location of procedure and procedure timing. And in Level 3, in comment level, there are two more data elements, procedure status, and treatment intent. So, really I think you are talking about a Task 1A issue, which is commenting on existing USCDI Version 1 data elements and classes. I think you are making a suggestion around the procedures, data elements within the procedures data class. If you can sort of restate it or someone else can restate what they think he said, we may be able to capture that.

Clement McDonald

Well, I don't know if I can do it in this second. But I could before the end of the day, if that would help. I would just take whatever is in FHIR and put it in. I don't have my hands on it.

Steven Lane

Al, do you want to comment on this discussion?

Al Taylor

I'm sorry, Steven, I am just jumping on. Can you restate it for me?

Steven Lane

Yes, sorry. Clem has raised an issue around the procedures, data class and elements that is currently in USCDI Version 1. And the potential benefit of providing greater clarification about diagnostic versus therapeutic procedures. He has identified the diagnostic procedures really fall more under an observation versus a procedure, I think. I am trying to capture what he was saying.

Al Taylor

It seems to me that what is missing from the procedure data class is results. You do a diagnostic procedure, right, you have a result of that or an outcome. And that might fit better into diagnostic studies.

Clement McDonald

Al, the point I am making is FHIR has already said that procedures do not apply to the diagnostic things. It is something that is invasive and is intended to change the state of the patient. They have a formal definition. And I think it would be helpful to keep that clear somewhere in this specification. And we can just copy FHIR's spec. I just don't have it memorized in my head, to keep people from blending the two and getting everything everywhere.

Steven Lane

So, I guess my question to you, Al, is this in scope for our Task 1A?

Al Taylor

I think asking for clarification or suggesting a clarification in the definition and scope of procedures, especially given the task that I think the task force is going to recommend adding diagnostic studies. Is that correct or not?

Steven Lane

Yes.

Al Taylor

Especially given the two, so a paired recommendation to clarify or to define the differences between the procedure and diagnostic study.

Steven Lane





And to Clem's suggestion, ideally align that with the work that has already been done in FHIR.

Al Taylor

As long as it doesn't, there's not a difference in CCDA. We would have to compare them all.

Steven Lane

I have not been capturing this in the spreadsheet, but rather in my chicken scratch notepad. I think it is pretty clear what we just said. Al put it very well, suggesting clarification in the definition and scope of procedures in light of the addition of diagnostic studies. Does anybody object to us adding that to our recommendations as a 1A? All right. That brings us actually – sorry, Clem.

Clement McDonald

I have a second one. It really regards vital signs. We should have some more optional attributes and vital signs like position, standing, sitting, lying, cuff size, types of machine, automated. There is probably five or six optional attributes that are really needed to allow any place that wants to to specify more exactly what they have done.

Steven Lane

So, Clem, that has been well captured. So USCDI Version 1 already has a bunch of this. Draft V2 does not add anything more. In Level 1 it is average blood pressure, BMI, and vital sign results date and time stamps. And then Level I, there is pain severity. So, the things you are asking for, cuff size, position have not been submitted for inclusion in USCDI . Someone would need to submit it before we could advance it.

Clement McDonald

Okay. Thank you.

Steven Lane

Clem, I will continue to apologize for raining on your parade. But these are great ideas, but it is not what we are able to do.

Clement McDonald

I have a good umbrella, so don't worry about it.

Steven Lane

Great. I have not been tracking either the public or the private comments. So, Leslie, is there anything we need to do before we go to public comment?

Leslie Kelly Hall

No. I think that we have discussed everything that has been put in comment in general. There is one question I saw regarding procedures, the definition asking for clarity on a specific row or a general recommendation.

Steven Lane

It would be a new row, I think in a 1A recommendation. We have not previously touched on that. Though, we did touch on diagnostic studies. So, I think we would tuck this into that recommendation requesting that greater clarification. Al, I had forgotten that you were going to be gone for a little while. So, thank you for hopping back.

Leslie Kelly Hall

Great. I think that's it. Mark has one more comment.

Mark Savage

Just checking, if there was time to discuss the recommendation to include sexual orientation and gender identity from Level 2 to V2.





Steven Lane

Let's do that after public comment.

Mark Savage

Thank you.

Steven Lane

And find the row, Mark.

Mark Savage

Yes, I've got them.

Public Comment (01:22:19)

Michael Berry

Operator, could you please open up the line for public comments?

Operator

Yes. If you would like to make a comment, please press star one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star two if you would like to remove your line from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys. One moment while we hold for comments. There are no comments at this time.

Steven Lane

Great. Thank you very much. For members of the public listening in, thank you so much for your participation. We appreciate you being here, even though you are very quiet. I thought we might have had a public comment coming from DaVinci today, but apparently not. So, we will take that up next month. Mark, you are on row 28 I believe.

Mark Savage

Yes.

Steven Lane

Which is specific to gender identity. Does that include sexual orientation or are those on two different rows?

Mark Savage

28 and 30. So, that has the two of them together, but they are listed as different data elements, so I did them separately.

Steven Lane

Perfect. I see that so far CMS has supported inclusion of sexual orientation and gender identity. So, I think the question is simply whether we as a task force want to add this to our list of requests. These are as new patient demographic data elements that were not included in V1, were not included in draft V2, but are under Level 2. I support it, personally. Does anyone feel that we should not add this to our list of requests? No objections. Anyone want to specifically speak out in support? We already have Mark and CMS on record.

Mark Savage

And Steven.

Steven Lane

I don't count.

Ricky Bloomfield





This is Ricky. We support it.

Hans Buitendijk

This is Hans. Lots of good work in progress in HL7 to get clarity on where to communicate what. So, same comments as before.

Steven Lane

Which same comment? When you say lots of good work, do you mean their implantation guide is ready to go? Or does HL7 need to prioritize these?

Hans Buitendijk

Good work in progress. It is not finished.

Steven Lane

So, would this be one of those caveats saying that this would be dependent upon completion of the implementation guide?

Hans Buitendijk

Correct.

Steven Lane

Are you okay with that, Mark?

Mark Savage

Yes, as long as we add the sentence, "Make it so."

Andrew Truscott

I just put a link in the chat here around some of the discussion of gender within the patient resource. So, this is discussed in R4. So, it would be applicable to the patient resource in US Core and something that can be used even if it isn't mandated currently.

Steven Lane

That is fine. Well, I really want to thank you, Mark, personally for the masterful job you have done bringing forward really important data elements for inclusion here. I think we are doing a real service to our community by covering these important topics.

Mark Savage

Thanks, man.

Steven Lane

Which brings us right up to the end of our hour and a half, our time together. I just can't thank all of you enough. We will be burning the day and midnight oil putting this all together into documentation and getting that off to the HITAC before the end of this week. I think we should still come together next week to kind of pat ourselves on the back, look at the documentation, start thinking about how we are going to move into this next phase of our work. Does anybody disagree? Mark gave us two thumbs up on that. All right. Great. I hope you all appreciate the fact that I got a new camera, so you've been able to watch me struggle through this entire meeting. So, thank you all. Have a wonderful day. Again, the public will be better for the work that we have done here, and I cannot send enough gratitude to all of you for your volunteerism. Have a great day.

Mark Savage

Thank you Steven and Leslie. And ONC staff, thank you.

Andrew Truscott





Thanks, Mark.

Adjourn (01:27:59)

