Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTEROPERABILITY STANDARDS WORKGROUP MEETING

March 15, 2023 10:30 AM – 12 PM ET

VIRTUAL

Speakers

Name	Organization	Role
Sarah DeSilvey	**Gravity Project** **Larner College of Medicine at the University of Vermont**	**Co-Chair**
Naresh Sundar Rajan	**CyncHealth**	**Co-Chair**
Pooja Babbrah	Point-of-Care Partners	Member
Shila Blend	North Dakota Health Information Network	Member
Ricky Bloomfield	Apple	Member
Hans Buitendijk	Oracle Health	Member
Christina Caraballo	HIMSS	Member
Grace Cordovano	Enlightening Results	Member
Raj Dash	College of American Pathologists	Member
Steven Eichner	Texas Department of State Health Services	Member
Nedra Garrett	Centers for Disease Control and Prevention	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Steven Lane	Health Gorilla	Member
Hung Luu	Children's Health	Member
Meg Marshall	Department of Veterans Affairs	Member
Anna McCollister	Individual	Member
Clem McDonald	National Library of Medicine	Member
Deven McGraw	Invitae Corporation	Member
Aaron Miri	Baptist Health	Member
Aaron Neinstein	UCSF Health	Member
Kikelomo Oshunkentan	Pegasystems	Member
Mark Savage	Savage & Savage LLC	Member
Michelle Schreiber	Centers for Medicare and Medicaid Services	Member
Shelly Spiro	Pharmacy HIT Collaborative	Member
Ram Sriram	National Institute of Standards and Technology	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	ONC Staff Lead

Name	Organization	Role
Abby Viall	Centers for Disease Control and Prevention	Presenter

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

Michael Berry
Good morning, everyone, and welcome to the Interoperability Standards Workgroup. I am Mike Berry with ONC, and I would like to thank everyone for joining us today. All of our workgroup meetings are open to the public, and your feedback is welcomed, which can be typed in the Zoom chat feature throughout the meeting or can be made verbally during the public comment period that is scheduled for about 11:55 Eastern Time this morning. I would like to begin rollcall of our workgroup members, so when I call your name, please indicate that you are here. Let's start with our cochairs. Sarah DeSilvey?

Sarah DeSilvey
Here.

Michael Berry
Naresh Sundar Rajan?

Naresh Sundar Rajan
Here.

Michael Berry
Pooja Babbrah? Shila Blend? Ricky Bloomfield?

Ricky Bloomfield
Good morning, I am here.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Christina Caraballo?

Christina Caraballo
Good morning.

Michael Berry
Grace Cordovano?

Grace Cordovano
Good morning.

Michael Berry
Raj Dash? Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Nedra Garrett?

Nedra Garrett
Good morning.

Michael Berry
Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Michael Berry
Bryant Thomas Karras? Steven Lane?

Steven Lane
Good morning.

Michael Berry
Hung Luu will not be able to join us today. Meg Marshall?

Meg Marshall
Good morning, I am here.

Michael Berry
Anna McCollister? Clem McDonald? Deven McGraw is also not able to join us today. Aaron Miri? Aaron Neinstein? Kikelomo Oshunkentan?

Kikelomo Oshunkentan
I am here, good morning.

Michael Berry
Mark Savage is not able to join us today. Michelle Schreiber?

Michelle Schreiber
Good morning.

Michael Berry
Shelly Spiro?

Shelly Spiro
Good morning.

Michael Berry
I believe John Garguilo is covering for Ram Sriram from NIST today. John, are you with us yet? Hopefully, he will join us soon. All right, thank you, everyone, and now, please join me in welcoming Sarah and Naresh for their opening remarks.

IS WG Charge (00:02:21)

Sarah DeSilvey
Welcome, everybody. We have a fairly full agenda as we welcome guests. We are very grateful for Michelle Schreiber and Abby speaking on facility information specifically from CMS and CDC. We are going to review the charge, and then, after the presentations from CMS and CDC, we hope to resolve some of the outstanding draft USCDI V.4 elements and move quickly on to Level 2 elements. A reminder that as we review our work plan and timeline, we do have to start working on our final recommendations. We sent that out in the homework for this week, so please try to start thinking about how we might frame any area that requires specific comment for our final recommendations. As always, we will close with our public comment, and then we will adjourn at noon. Naresh, any comments?

Naresh Sundar Rajan
You pretty much got it, Sarah.

Sarah DeSilvey
All right, thanks. Next slide, please. Just a reminder, as always, that our charge is to review new data classes from draft USCDI V.4 and Level 2 data classes. We did mention, again, in the homework that we are hoping that individuals who put any comment on a USCDI V.4 element in the Level 2 section resolve it, just for clarity, and add your comments to the area on the draft USCDI V.4 element where they belong, just as we try to move quickly through the Level 2 elements that remain. Next slide, please. This is a rough view of the elements that we have covered so far. Again, we need to resolve many of the elements in yellow that we have already covered, so we hope to return to those after our guest presentations today, again, just ensuring that if there are any areas that need adaptation from the submission as noted, we can take the lead on authoring those elements, but otherwise move forward with formal final recommendations from the committee. And then, we also, again, hope to cover those Level 2 elements. Next slide, please. It is now my honor to welcome our colleagues from CDC and CMS. Michelle?

Michelle Schreiber
Thank you. Do you guys have the most recent slides? Did you update them? I can share my screen.

Michael Berry
Yes, we do.

Facility Information Data Class (00:04:50)

Michelle Schreiber
Okay, great, thank you. Thank you, and it is a pleasure to be, first of all, participating in this group and, second of all, here today speaking for CMS, and this is a collaboration between CMS and CDC, and I am very glad to welcome Abby Viall, who is a coordinator between CMS and CDC and a wonderful liaison, and she will be speaking to some of the CDC aspects on this. CMS, CDC, and others across the federal government try to align what we are looking for to promote and really align our initiatives as well, and so, we thank them for being here today. We are here to talk about the facility information data class, and we can move forward to the next slide, please.

There are a number of certain identifiers that help us understand what the facility and, frankly, even provider is who is giving care. For CDC and CMS, this is obviously important, as we produce quality reports that are specific to setting provider and even organization, and it is important when we start talking about provenance as well, and I just want to throw some support into provenance so that we can actually identify correctly where information is coming from. So, the facility identifier data element is really the opportunity to provide that granular patient and setting data, and it tracks back to the organizations. It supports ONC priorities as well, such as providing high care for patients, reducing healthcare inequities, and promoting interoperability, and they have really been identified as a joint priority by both CMS and CDC for public health, surveillance, reporting, and emergency response. Next slide, please.

There are a few facility identifiers that are widely used by CMS, and they are listed here. The CCN is the CMS certification number, the PTAN is the provider transaction access number, the NPI, as we all know, is the national provider identifier, and then, CLIA is actually a lab designation, clinical laboratory improvement amendments identification number. So, these identification numbers allow for the accurate identification of a facility, and they are really essential for us to analyze facility-level data and allocate resources. They became particularly important, for example, in the pandemic response to know who was doing what and who needed specific supplies, staffing, or PPE, and we would really encourage the organization identifier, which is what these are, to be complementary data elements for the facility identifier because they are really both ultimately necessary.

However, these are not enough alone because under the CCN, for example, systems sometimes will use the CCN as an umbrella identifier, and multiple hospitals can be categorized under the same CCN if that is what a system wants. It has implications for survey and certification, it has implications for some other things, but it does not therefore allow for the granular identification of a specific hospital because, again, you could have multiple hospitals under a single CCN number. It does not happen all that often, but it does indeed happen. This is something from a patient safety point of view that patient safety organizations have really been seeking, that when CMS posts its information, for example, they are able to get information by specific facility.

And so, that leads us to the organization identifier on the next page, and I am going to turn to Abby here for a moment, but the facility identifiers are necessary but not always sufficient, so the organization identifier complements that. NHSN, for example, uses organization identifiers, and they use it in cases such as COVID reporting. So, COVID-19 hospital reporting to HHS and patient safety monitoring are done through organization identifiers that may not quite be ready yet for primetime. We think the first ones that we outlined

are ready, and we recommend that they go in Version 4. We are recommending this to reclassify the organizational identifier as a Level 2 and consider for future versions. Abby, let me pause and turn to you for a moment, because this really came from CDC.

Abby Viall
Thanks, Michelle, and I think you have actually covered it quite well. We recognize that this is, frankly, a comment-level element right now, but when we are looking at this space and the data that we need to, again, not just dig down to assist them, but dig down to an individual facility, which is what you really need for not just attribution, but action, whether it is on the patient safety piece or surveillance and response, especially in emergencies. You cannot just figure out that there is a need for supplies in an organization, you need to know the specific facility. You need to know where to send those supplies. So, for example, ASPR relied on not just CCNs, but the org IDs that were sort of the next level down.

So, while we recognize that the focus here was on facility, the facility class, and the elements that have been proposed there, we thought it was imperative to bring this piece into the conversation because ultimately, we see them both as complementary and necessary. Again, we are recommending that this group consider as part of its final recommendations that at least the org ID be considered for Level 2, given that there are broad use cases that are nationally in use, for example, NHSN, which has been used for COVID-19 reporting as well as patient safety reporting for a very long time. Teletracking and HHS Protect both had org IDs used as well, so we think there is enough here to at least elevate this element beyond where it is currently classified so that it is available for consideration in future USCDI versions, again, because we see these as important complements.

Moving on, I think we want to cover the rest of the facility class elements, so move to the next slide. In keeping with that rationale for organization ID, there are elements that are being proposed as part of the facility class that we think can at least help address this issue of broad umbrella organizations using a single CCN, NPI, or CLIA number, and we see facility name, and frankly, we have added facility address for your consideration here as well, since it is Level 2, as important complements to the facility identifier. Again, these allow you to dig beneath a facility identifier when it does apply to multiple facilities. This information, name and address, can help you pinpoint the actual building or location from which specific data are coming.

And so, again, this is really important when you are thinking, not just in terms of attribution, but in terms of action, whether that is for quality improvement or public health response. For example, if you are seeing data that suggests lots of *C. diff* cases, it is not enough to know that it is potentially within an organization with nine facilities. You want to know if it is in a specific facility because you have a potential outbreak, and you want to go where that outbreak is, and facility name and address information will help make action feasible. So, there are widely used standards, including US CORE location resources and names, so we think it is reasonable to move these forward, again, because they are complements to the facility identifier, and frankly, as a package, all of them let us identify where the information is coming from so we can provide support, action, and response for that information. But again, I just want to pinpoint that we recommend moving forward with facility name and considering address as well. It is a Level 2 element, and it would complement the broader rationale for moving both forward. Next slide.

So, the last element that has been put forward for consideration for USCDI Version 4 is facility type. Next slide. Again, we support this element. It is important because it provides contextual information that we

think is useful for surveillance, compliance, and public health action. It is important to know what kind of institution you are seeing outcomes or service data from. This kind of facility typology is used, for example, again, in the context of COVID-19 reporting, where, if you are seeing capacity data, you want to know what kind of institution or hospital is coming from. You need to know the burden. This is also really important for disparities work. You need to know where people are accessing care and how service, quality, and outcomes are varying in terms of where that access is coming from. So, type is important.

We also see it as an important complement to encounter location. So, if you are asking what the difference is, we see facility type as sort of a broader aggregate that tells you administratively how a specific kind of facility functions, where as encounter location tells you where care is happening within a facility and how a specific area is functioning. So, we see them, again, as complementary, not redundant, and we do think there are some applicable standards to work from in terms of defining facility type. For example, there is the NUCC healthcare provider taxonomy for nonindividuals, NHSN does have a facility type taxonomy, and FHIR location may be a starting point.

That being said, after a lot of consideration, and I do not want my remarks to suggest that we do not support this data element, when we dug into how this element has been defined and described so far and compared it to encounter location, we did find some overlap and leading of the edges that made us think that while it is important to move this forward, it should be coupled with a recommendation to and a commitment to develop applicable standards and make sure that any standards proposed for and linked to this element are clearly differentiated from those that have been proposed for encounter location. We do not want to muddy the waters between these two elements, which, again, can and should be complementary in terms of their applications. That being said, that also leads us to say that as this element moves forward, we recommend that its development support clear differentiation from encounter location and the associated standards there.

So, again, encapsulating it, I think this is important. It supports a lot of public health and healthcare quality use cases. That being said, we do think it needs a little development, but we do not think that that needs to stop it from moving forward because, frankly, it is not going to immediately go into use if it is in Version 4. I will stop there, and it looks like we already have a hand raised.

Sarah DeSilvey
Thank you so much. We have many hands. Thank you so much, Michelle, and Abby. That was incredibly helpful. There has also been a fair bit of chat in the Zoom chat that you can see with questions and support for these elements you have presented. I am going to move to welcoming some of the questions and comments. Ike, I believe you are first.

Steven Eichner
Thank you so much, and thank you, Abigail, for your presentation with the Texas Department of State Health Services. I have been long involved in USCDI development and have had lengthy discussions about USCDI Plus as well. One of the places that I started out with USCDI from a personal perspective was looking at how we address facility information in the context of the USCDI and the context of public health data exchange. One of the things that I have struggled with a little bit is looking at whether USCDI should be focused on personal information while a second set of collection should focus on facility and professional information.

That being said, I am really in favor of a consolidated approach for elements that EHRs need to support, not necessarily looking at their particular use case, with a second layer of information looking at the use case to support a different transaction. For example, looking at an electronic case report to public health might include facility information and personal information that is not in a single USCDI class. So, one of the things I would really like to see, building on the strong foundation that you presented, is looking at figuring out how we take the USCDI and the use cases we have looked at for the USCDI in the USCDI Plus and transform that concept so we have a strong underlying set of data and standards within the electronic health records and similar technologies, and then having a strong interpretation layer, business interpretation layer, or business case layer that describes what is needed for particular business transactions laid on top of that.

Some of that may be supporting healthcare coordination in the healthcare space; some of it may be supporting public health reporting and public health data exchange. I think that comes in a much stronger way of moving forward and making it easier for providers and EHR developers to look at ensuring that they are including the relevant data points, if that makes sense.

Michelle Schreiber
I think what you are saying does make sense, so, thank you for that. Not only is there perhaps clinical information that is used for some cases, but you have to be able to track that back, really, to the exact setting or even provider, and I think that is what you are saying, that these need to layer on each other.

Steven Eichner
Right, as well as providing clarification for everybody. If USCDI Plus is collecting other data or is supposed to have other data, with respect, where does it fit into the matrix, and why is there a particular element in USCDI Plus versus USCDI? You made a great argument, a great position, and a great presentation supporting the inclusion of those elements in USCDI Basic or whatever you want to label it, and I am not sure what gets left into USCDI Plus from a data element perspective. Now, if USCDI Plus becomes a list or a collection of business cases that leverage the data in the USCDI for public health purposes, that might be another approach to consider.

Michelle Schreiber
I can tell you that for USCDI Plus, at least for the quality side, and Abby might be able to speak from the public health side, the elements in USCDI Plus were really those used for a specific use case, such as quality measures, for example, and there are elements of those that may be in the numerator or denominator of what a quality measure might be. Here, the facility information, the facility ID, is really not specific just to quality information, but it is a way of everybody being able to identify the appropriate facility, and that is why we are supportive of this being part of what we are going to call the parent USCDI.

Steven Eichner
Right, but I think we can take it up in a different venue, perhaps. The quality measures are made up of patient data first and foremost, so again, I am not sure about the practicality of splitting that out. We can take that up in other places.

Abby Viall

Steve, as I understand it, in USCDI Plus, there are multiple tracks. They include a quality measure track. There is actually also a public health track, and I think several others.

Michelle Schreiber
And a research track, and several others.

Abby Viall
I think what you said earlier, though, was really important. What we are saying about this data class and, frankly, also the org ID, is that there is a package of information that should be complementary to what we are doing in terms of the individual-level information and that we need for multiple purposes. It is not just quality measurement, it is not just public health, and frankly, all of this goes to research, too. In those cases, we think that because this is core to multiple applications, and certain elements are probably needed across those, and we think these are some of them, they should really be in USCDI core, and then, as you noted, there might be other additional facility-related elements or, frankly, other individual-related elements that are more niche or specific use cases, and those might go in USCDI Plus.

I think what you said about differentiating and being able to clearly communicate why one is in one place or the other is critical, but the argument we are making here is that these should not be relegated to USCDI Plus because they are core to so many applications. It is not a specific use case, whether it be public health research or quality measurement, and again, just reinforcing what you are saying here, we think these should be in the core, and there might be others that go in Plus, and to your point, we need to do a better job of differentiating and explaining all of that, but our argument for these is that they are fundamental, and hence a core proposition.

Sarah DeSilvey
Thank you so much, Abby. I am going to try to move us to some other comments because we only have a few more minutes in this discussion topic, and I want to make sure that we move on. We have had preexisting conversations regarding differentiation of USCDI Plus from USCDI, so I just want to honor that. Moving on to Hans.

Hans Buitendijk
Good morning, Hans Buitendijk. I have a couple of questions. First, I want to confirm that in the discussion, and I think I heard it right in the slides as well, there is a clear distinction between a facility that is much more of a location, and a building is a place like that, versus an organization that has ownership, uses a facility, and provides that. If that is indeed correct, that would be helpful to confirm, as the interpretation downstream is going to be very different depending on what it is. You can talk to an organization that has responsibility, in a way, and a location is where you want to know about that if there is a particular geographic space that you are interested in. So, that would be the first question, to make sure that that is indeed still maintained as a difference. I see Abigail shaking her head. I take that as a yes, which is great.

The second part, which is a little bit more, is that facility information has meaning in the context of other data classes. On its own, it does not do much. So, an encounter has facility information that might be of interest, but a care team might not. We can go across the different data classes that are in USCDI where facility information is of interest, and other ones are either not relevant or it is already assumed with the relationship that it has to other data classes. Generally, I think that is a comment that we need to look at,

that having individual data classes, like facility, without understanding the context of the other data classes that are important to collect that data on is going to get confusing downstream. Where do we care about that?

So, a suggestion would be that we not only define what data is relevant about a facility as a starting point, but also, where is it meant to be associated with, and that can, in turn, inform downstream use, whether it is through standards or otherwise. Where do we care about it that we have it available? The third one is specific to the facility type, where the vocabulary in the proposal was not identified, and there is a wide variety of potential facility types that everybody can use, and there is a lot of variation from one organization to the next as to how they allocate and define their facilities and as what they consider them. Particularly, if the interest is to be able to use that information for secondary data use as it is being shared, what is really the vocabulary that we aim to align on that can enable such national-level or larger jurisdictional-level analysis so that it has meaning, and it is not just what I am putting in or what you are putting in, but something that we are collectively trying to align to?

So, the second request is that we really are very specific about what it is, or that we recognize that, at least initially, it will be all over the map, so there will be types, but it will be all over the map, and some mapping will have to be done. Lastly, I just note that we assume that the facility identifier is meant to be unique, as in not just within the organization, but we really, truly get to the facility across organizations and areas, and therefore, we can achieve that with the scheme that is going to be used and suggested so we know exactly which facility is no matter where we are. Those are some thoughts and suggestions on what would be needed to help interpret the USCDI and take a next step, which is currently missing.

Michelle Schreiber
Thanks, Hans. I think the ones that we are very support of right now are the facility identifiers, CCN, PTN, NPI, CLIA, plus the facility address, which are unique. We think that in the future, we will also need the organizational identifier, again, because the CCN number can be an organization that has multiple facilities associated with it, and perhaps a little bit more research needs to be done on the facility type, so, thank you. Those other numbers are very unique, though, Hans.

Hans Buitendijk
Yes, and it would be helpful to clarify that in the definition, that those are the types of identifiers that you are looking at where they are available for those facilities, so that would be helpful as well with the type, so I appreciate that.

Abby Viall
Hans, I will just say that is actually why we recommended for type. Yes, we think it is important, and again, the NUCC classification for nonindividual providers is a good starting point, but it is definitely an area where there needs to be some work, and that is why we recommend that it moves forward, but only with this recognition and commitment to engaging folks to do this additional standards development and standards identification that will avoid the blooming of a thousand flowers of typology across different settings that would otherwise be the case right now because there are so many options. So, I 100% agree with you.

Hans Buitendijk

Yes, and if it is possible to clarify that the facility identifier is meant to be an address and an identifier, one of the types that you mentioned, that would be helpful because the current definition or draft would not clarify that distinction.

Abby Viall
If Michelle will indulge me, I think what she might have been saying is that we need the identifier, the name, and, as we proposed, the address as well. You need that package right now in order to ensure that you can kind of dig down into all three. Michelle, I think that is what you were getting at, but if I am wrong, definitely clarify.

Hans Buitendijk
That is what I thought I heard as well, and I think that needs to be a recommendation, to enhance the definition of facility identifier to encompass those two concepts. Address and identifier are not necessarily looked at the same way, depending on who you talk to.

Sarah DeSilvey
Hans, that sounds like really critical information to include in a final recommendation **[inaudible] [00:32:20]**

Hans Buitendijk
Right.

Sarah DeSilvey
The extensive documentation that CDC and CMS have on these elements within the draft worksheet can easily be transcribed and then added to an order to include that, which I think is actually really critical.

Hans Buitendijk
That is probably a general comment. We have seen a number of areas where the definition draft includes part of a submission, but not necessarily everything, so it is very hard to understand when we are supposed to assume whether that submission as a total is meant to be adopted or whether it is a part of, and this is a good example where it sounds like a little bit more needs to be pulled from a submission to make that clear.

Sarah DeSilvey
Fantastic. That makes a lot of sense. It seems like the understanding is in hand, it is just communicating that in the final recommendation in the text. Shelly?

Shelly Spiro
Yes, thank you, Abigail and Michelle, for that great presentation. I totally agree with my previous colleagues who have discussed this. I have a couple of comments, and then a question. First off, I totally agree that we need to move forward with this, but I would encourage that the USCDI Plus harmonize with what is being done here, especially for those who provide ancillary services that might not be connected within one location and where multiple care team members have to communicate the information, especially with facilities, such as transitions of care and medication administration records. So, harmonizing is going to be extremely important, especially as we get into population health and being able to exchange, so I support the two data elements that have been proposed.

My question is in relationship to the address on Level 2 of where you want to go in the future, I would encourage you to include room and bed. These are really important, especially as you get into facility. You cannot identify where the patient is just form the address of the facility. Especially when we look at delivery of medications and other types of information that has to be exchanged where the patient is for pickup, these are all really important pieces as we move forward. Thank you.

Michelle Schreiber
Thank you.

Abby Viall
Can I ask a follow-up question on that? This gets back to typology, but also, I am wondering if the room/bed information is something that… Would you see that as part of address, or is that also part of encounter location? I think that has also been sort of the challenge. I think that is also something we need to grapple with, is where it is that facility administration that serves one function and where it is to understand the individual encounters, what the differentiation is, and how we develop the two out, because the encounter is more at that individual level, whereas the facility is a different class that we linked to. That is something that I have been grappling with and that I think could also continue to be grappled with after this version of USCDI.

Shelly Spiro
I would look at it the same way that we look at anything where we are trying to identify a patient, and so, maybe it is applicable in both places, the encounter and the address. You might have different use cases for either one, but they are both important aspects of both the address and the encounter.

Bryant Thomas Karras
I would just comment that if you make one of them too granular, it becomes impossible to use for other use cases. If public health is trying to assess the capacity or health impact at a given facility, analyzing it by the facility as a whole, not individual beds, is what is necessary, so we have to make sure that we do not bundle too much into a given element, or it makes that element unusable for other use cases. I just wanted to lend my support. I really think these data elements are all critically important. Public health, after all, is the who/what/where that we need to be able to analyze, so I think we do need to move these forward. When my team dug in on that type category, no single vocabulary set that we could find had everything that we needed, so I think there is some harmonization that needs to be done to figure out how that one actually works, and perhaps an ontology or an ability for a given blanket facility that serves multiple roles at a given address to indicate all of the different types that are occurring there so they can be analyzed properly. It is going to be a challenge, but let's put it in the queue.

Sarah DeSilvey
Thank you so much, Bryant. We have time for one more comment. This is the end, and Nedra is there.

Nedra Garrett
Yes, hi, thank you. I just wanted to mention the need for this around health equity, particularly as we are studying homelessness and looking at facilities that typically serve the homeless, so the way that it is actually structured now and the standards that support it are not really able to capture correctional facilities, qualified health centers, and things like that, so I just wanted to add that note.

Sarah DeSilvey
Thank you so much, Nedra, for just honoring the significance of that critical aspect of this element. Any other final comments before we move to the next elements? Again, thank you so much, Michelle and Abby, for coming to us with these critical elements, and thank you for taking the time to really analyze other elements in the ecosystem and give comments on what is ready for primetime and what might not be. We appreciate that as well.

Michelle Schreiber
Thank you for allowing us to be here and comment today.

Comments and Recommendations – Draft USCDI v4 and Level 2 Data Elements (00:39:24)

Sarah DeSilvey
Of course. I believe we are moving on to the next phase. We have a lot of work to do, hopefully, to get elements resolved, again, to get started on writing. I think we are going to move to the share drive at this time, the Google sheet. There do seem to still be some data discrepancies and comments that we tried to resolve last week, but if you have any specific concerns regarding comments that are missing or that are where they should not be, please let us know. We have some wrap-up to do on workgroups, and we have to revisit some of the elements that we had guest presentations on prior, so when AI is ready, we will go to the worksheet.

Just to frame us as AI takes us there, although we have had guest speakers on many elements, we did not have a final discussion on them, and again, given the timeline, we have a lot to do to get writing on our final recommendation, and again, thank you, Hans, for elevating that. So, before we move on to Level 2 elements, I just first of all want to note that Pooja, you and your workgroup submitted a really lovely rationale from the workgroup as part of medication adherence and medication instructions. That was something that we had yet to discuss in this workgroup. Any comments based on the documentation that you have in those elements?

Pooja Babbrah
Thanks for that, Sarah, and thanks to the team that worked with me on this. I think Shelly had mentioned that she put a couple comments in a little bit further down, so we just want to make sure those are captured, and Hans, I know you sent me an email this morning. I apologize that I did not have time to read it, so I do not know if there was a last-minute edit that we might have wanted to do. Hans, I do not know if there was something that we needed to change, but I think we are pretty much ready to make a recommendation.

Hans Buitendijk
The comment that I put in was that we include quantity in there, and we want to double check that since those and those units of measure are already used in USCDI Version 3, it might not be needed, so it is just a duplication, perhaps, that exists.

Sarah DeSilvey
Thank you, Hans. Can we go over to the next column? I believe that is where you put the recommendation of the workgroup, correct? Pooja, I believe Hans noted that on the quantity element. Any response to that? Shelly, I see your hand is up.

Shelly Spiro
Yes. The instructions and the dose are different. You do not say in the instructions to take 500 mg twice a day, you would say take one tablet or two tablets. So, at least in terms of the definition of a prescription, the directions dosage and the directions quantity are two different data elements, Hans.

Hans Buitendijk
That is okay. I just wanted to make sure there was no overlap.

Sarah DeSilvey
So, if folks have had a chance to review the final recommendation for these elements, hoping that we are able to do a final disposition, any concerns with the elements as defined by the subgroup in the recommendation for both of the elements that were covered? All right, no concerns noted. That is one of the elements that we need to address. I also do know that Care Plan also did work on that element as well. So, that is the resolution of the subgroup. Again, Pooja, thank you for leading that work. We are very grateful.

We never did a final disposition for the health status elements up above. We talked about alcohol use and substance use and had guest speakers on physical activity, but what we are looking for at this time is basically whether there need to be adjustments to the recommendation as it stands or whether we are good to go on those three elements. Again, we can note some of the subtleties of the differentiations between prescribed substances, associated terminologies, and the difference between these substances in our recommendation. We had a very extensive conversation about the difference between, for instance, prescribed medical marijuana and substance use disorder with marijuana as a substance of concern. So, I am hoping we can, again, discuss the disposition. Hans?

Hans Buitendijk
In general, on the substance abuse and alcohol abuse, it would be helpful to have a statement for those elements as part of the support that we suggest more clarity on the scope, particularly in these two cases, "the use of, but not limited to," and the submission that make it not clear how much of the submission text is actually intended to be in there. Our discussion has been more around a very targeted set of data elements, so when we look at the draft, we need to make sure we are clear about that.

Sarah DeSilvey
Fantastic. One of the things we are hoping to do is actually assign responsibility for drafting some of the elements, so if it is not just a passthrough, like all done, and we need to make sure that the recommendation includes some subtlety, we are hoping to have leads from the committee start working on that so we can get done in time for our submission to HITAC. So, if some folks could consider taking responsibility for starting to draft some of those subtleties, it would be great. We are turning to the disposition. So, based on the presentation from AHA, Lloyd from Dogwood, and HL7, and based on the conversations we have had regarding alcohol use and substance abuse, are we okay with a disposition of recommending for those three elements? It seems so.

Again, if there are subtleties that need to be contained in the recommendation, please consider whether you can help with that. Of note, we also did not create a final disposition of the care preferences down

below that we discussed with the wonderful guests Terry O'Malley, Holly Miller, and Maria Moen, so can we reconsider those? I note that there was a really clear recommendation that was repeated across multiple members of the IS WG about redefining and naming the class because at present, the goals class is now containing other elements that are not specifically just goals, so there was a thought reiterated across multiple commenters from the IS WG on renaming the class to goals, preferences, and priorities, in line with the precedent stated in Holly and Terry's presentation. So, there are two questions, first, whether we agree and go forward with a recommendation for the inclusion of these two terms based on the subject matter presentation we had from Terry O'Malley, Holly Miller, and Maria Moen. Shelly?

Shelly Spiro
I totally agree. We should rename the class, and we should go with their recommendation.

Sarah DeSilvey
Hans?

Hans Buitendijk
I believe that this one also, based on discussions, that focusing it on what aspects… It looks like it is primarily the goals part of it where we need to have some clarity in the recommendation to make sure that that is what we are looking at. The second comment, which might come back, is that in the discussion on the preferences, care experience preferences, treatment intervention care plan, and advance directives, I think we may have a larger topic as part of the care plan that we want to reflect on how they all tie together.

Sarah DeSilvey
Correct, yes, that is really critical, and those comments are noted. If we can humor ourselves and just resolve facilities, I believe that is the last element of draft USCDI V.4 that we had to review and dispose of, so if we can close with facility, again, really picking up the recommendation of our colleagues at CDC and CMS regarding identifying the critical elements, noting some of the evolution, specifically in type, but the other elements that they defined were really critical, and also stating on our recommendation the coupling of those and how they are important together. I also heard the comment recommending some of the Level 2 for organization. So, do we agree with the recommendation from CDC that is very clearly written? And then we could expand on it by talking about how these elements are coupled, which was part of the original submission. Any concerns?

Steven Eichner
This is Steve Eichner adding a caveat that there should be alignment between this and USCDI Plus, not necessarily exclusively for these elements, but for others as well.

Sarah DeSilvey
That makes sense. Ike, would you mind putting that in the comment so we can work that into the text of the final recommendation?

Steven Eichner
It would be my pleasure.

Sarah DeSilvey

Thank you so much. Any concerns with moving forward with those last USCDI V.4 elements that we had to formally dispose of?

Hans Buitendijk
I have the same comment. We need to clarify these.

Sarah DeSilvey
Yes. So, in light of that, what we are hoping to do is, when appropriate, when the speakers who are part of the IS WG leaning on our members of the IS WG to help us draft that final recommendation early and put that in the spreadsheet so that we can ensure the subtleties that we have discussed and represented in the discussion are part of our final recommendation. Again, we are hoping to get some draft final recommendations going shortly, though I do not remember exactly what column it is, because the capacity for us to put those subtleties in the final rec would be helpful. Yes, Hans?

Hans Buitendijk
On that note specifically, are you suggesting that over the next couple of days, we volunteer for different rows, or are you going to start with some, and then we jump in? It is not clear yet how those steps are going to be taken to get from the discussion the general sense of "Yes, we want to support it, but we have some clarifications to be made." How exactly are you suggesting that we jump in, or do we wait for something to drop in and then react? That is not totally clear to me, and I am afraid that as a result, we might wait for something to drop in, even though we were intending to put something in already.

Sarah DeSilvey
My apologies. So, what we discussed in our cochairs meeting was a request, if there was a subgroup, such as the ones Hung, Pooja, or Mark led, or if there was a presentation from within the IS WG members, such as that of CDC and CMS today, that those individuals take the lead on presenting the final recommendations for those sections, since they are representing the content most directly, and we ask for that to happen as soon as possible because those are some of the areas we all need to collectively think about the most. And then, for the elements where we do not have an expert within the IS WG, we would need volunteers to start leading on that. I think about elements like physical activity or substance use and alcohol use. We need volunteers in short order to start, and we will put your name in the column so that we can clearly have an owner so we can start drafting those final recommendations. Hans, does that make sense?

Hans Buitendijk
Yes, that is clear, thank you.

Sarah DeSilvey
Lovely. Is that okay with the workgroup and subgroup leads and the presenters from CDC and CMS, to tap you all to lead the final rec?

Michelle Schreiber
Yes.

Sarah DeSilvey
Wonderful. Thank you so much. Abigail?

Abby Viall
Sorry, that was an accident.

Sarah DeSilvey
All right. So, I believe now, we can pivot to the Level 2 elements. Just thinking about time, although we are okay on time, I want to go directly into care plan because we started there last time. I know that Mark is not here, but I know there is a presentation from the subgroup. I want to note what Hans discussed was that some of the elements that are in Level 2, such as advance directive and care plan, are related to the conversations we have been having regarding goals, preferences, and priorities, and I believe there are some thoughts on that. Hans, you actually put a recommendation in the worksheet. Are you representing this work today for us?

Hans Buitendijk
If we have time, then I think this would be great to start. It was just dropped in. Mark pulled a number of people together. Unfortunately, he cannot be here today. Based on his summaries, the discussion, and a couple of additional comments, we put together what a recommendation and a rationale for it would look like in Column J, so it would be J22. That generally outlines that care plan. There are two aspects of progressing.

If you look at what currently is implemented in support of the assessment and summary plan, it is a long name, so I might not have stated it correctly, but in there, the way that it is currently being supported is primarily a text narrative-oriented approach, and it would be very helpful to have the opportunity as soon as possible to type the care plan so it is more clear in what context that care plan exists because there are a variety of care plans that can be in play, but considering the variety of specialty care plans, which are interestingly in the discussion, that would be around multi-chronic care, pharmacist care plan, or even advance directive, they have characteristics of it when you start to dive into it, it would be good to identify what the common elements of a care plan are that we should focus on in the next round because it might be too soon to do that at this point in time from the conversation.

So, you see a split recommendation to do something now in USCDI Version 4 and do something later and begin to work on that so it can be ready for, perhaps, even USCDI Version 5 where a commonality across the variety of care plans is being addressed. So, that is the essence of it and the rationale as to why. I am wondering whether any of the other team members have additional thoughts or suggestions that were not totally addressed in here as we circle this around.

Sarah DeSilvey
Shelly?

Shelly Spiro
Thank you, Hans, for the summary. I was on that group, what was a little bit confusing… We did this with goals and patient preferences as we were moving forward with that particular data class, and goals is part of the care plan. Just as we have with some of the components of SDOH, they are put into different portions of the data classes that have already been identified, such as when you get into the four components of the care plan, which is your health concerns, including your observations, your interventions, your outcomes,

and then your goals. Those are the four components of the care plan. We have added some data classes to, as an example, health status that become part of the care plan, so this is probably the thing that needs to be fleshed out for the next version. Do we really continue to place those components in those sections that we have already identified as data classes, or do we incorporate it into a data class that is aligned with the care plan? I agree with Hans's comments, and I think we are moving in the right direction.

Hans Buitendijk
I think Shelly's point is important, and it ties into some of the comments in facility information as well. We are starting to see care plan as a great example of that, that on the one hand, you have goals, assessments, care team, or other, like medications, as independent data classes, but the care plan pulls them together, or other data classes pull in facility information. Those relationships are helpful to start to identify in USCDI more clearly as well because at times, it is one thing to have goals overall, regardless of the care plan, and it is another to have goals for a specific care plan, which might be a subset of all the goals. So, there needs to be a recognition that there are those relationships, and we need to start to figure out how that is defined in USCDI, unless we accept the ambiguity of only keeping them outside of a care plan or outside of another data class where it is also applicable. That might lead to different interpretations of what is really related or not, or what should be related or not.

Sarah DeSilvey
Thank you, Hans. Clem, did you have a comment?

Clem McDonald
I am just worried about making it so structured because that will be an additional work burden on providers. I guess the question is how structured can we make this when there is so much variety and different nuance in the care of patients?

Hans Buitendijk
I think that is probably a balance. Currently, there is a very narrative support to enable that, as you indicate, but the question becomes where such structured information is available, what do we want to do? Do we want to recognize that there should be information on there as part of a goal care plan? I think it is an excellent issue and challenge that we need to work with on what level of structuredness we want to support when available or that we want to support and provide. So, I think that is a great question to figure out what to do. Clearly, having data classes for a goal and for medications that are very structured in their setup, what does that mean for a care plan in pulling some of that information together? How structured should it be?

Clem McDonald
I agree with you, Hans.

Steven Eichner
One way we could address it without having to modify the data classes or the elements themselves is if there were a companion to the data element class list that identified which elements or classes were related to a particular business or clinical need. It would not matter which class it came from, it would just be an inventory of the related elements, and that is actually a neat way of doing it because then you could actually separate how you have implemented the exchange, whether you are using FHIR or other technology. It

does not necessarily matter how much you are getting it as much as identifying the critical elements for achieving a particular business or clinical need, whether it be conducting a procedure, ordering a procedure, an element of a care plan, or an entire care plan. Just a thought.

Sarah DeSilvey
Thank you. Steven Lane, do you have any comments? I saw you raise your hand, and then go off.

Steven Lane
Sorry, I was thinking of saving time and putting it in the chat, but I just want to remind us that this is another one of those data elements that has been discussed year after year. There is a clear value here, and I want to remind all of us as well, to Clem's comment, that just because we have something in USCDI does not force any provider or member of the care team to collect or document that data. What it does is provide a vehicle for the sharing of that data when, in fact, it is collected, and I agree that care plans are a combination of discrete elements and free text, and they should be flexible, but we need to start somewhere. We need to create the container that allows this care plan data to move to define what it is broadly, knowing that over time, this can evolve.

Sarah DeSilvey
Thank you, Steven. So, let's have a conversation and see if we can have a disposition of the element, and I also want to make sure we are understanding the suggestions for renaming. Any concerns with moving forward with the recommendation with care plan moving from Level 2 to a recommendation for USCDI V.4, based on the work that the subgroup has done, understanding all the caveats and needing to note that in our recommendation? I do not hear any. Can we now just make sure that we are focusing in on the renaming? Any concerns on the renaming that is suggested in the recommendation? I see no comments. So, if there are no comments on the element and no comments on the renaming, we are grateful for the work of the subcommittee, and again, Hans, just to note we would look for that subgroup with Mark and you all to draft the final recommendation that we would put in the recommendation to HITAC.

Hans Buitendijk
I think we can copy this, then, to the right column.

Sarah DeSilvey
Exactly. It is very lovely. It seems like it was built with that in mind. Fantastic. I am just hoping, given some of the connections that Hans made before, that we can move on to advance directive because, again, this relates to the goals, preferences, and priorities discussion we were having above. I want to note that I think I actually neglected to have a final disposition on average blood pressure, which was bumped for further consideration earlier, so if we can loop back to that before we close, that would be great.

Grace? Actually, Grace had to step out for a patient, I believe. Maybe we will postpone that until Grace is with us because I believe she is not with us right now because she is attending to a patient in need. Out of respect for her, we might move that until next week. It does seem fair, just given the fact that she suggested the element. So, can we move quickly back to considering average blood pressure? It was one of the early ones that we discussed. We were not ready to give a final recommendation on that one. We have had time to think, and there has been conversation in the draft spreadsheet. Any concern for moving forward average blood pressure as an element of USCDI V.4?

Hans Buitendijk
This is Hans. I think that particularly underscoring that it is the blood pressure measures, the time period over which they were collected, as was defined in the draft, and how the submission goes into a variety of other aspects of it will be helpful to underscore that that is the recommendation. It provides a starting point, and it has clarity to begin with without getting into some of the other complexities that the submission would be referencing.

Sarah DeSilvey
That is a very important note, and I feel like we can say that narrowing the recommendation to what we have agreed upon seems really critical.

Clem McDonald
Could I get some clarification? I do not know what it means by the systolic and diastolic components of the mean. Do you want to have them both as means? Mean is complicated because there are between-beat means and over-time means. I understand that the first sentence is fine, but you are saying you want the main… It may be better to phrase it as "must include both the mean systolic and diastolic pressure."

Sarah DeSilvey
That makes sense, Clem. We can ruminate on that in our recommendation, but can you put that concern in the spreadsheet, just so we can ensure that we do not lose it?

Clem McDonald
I am only adding it for clarity.

Sarah DeSilvey
No, it sounds really critical. That makes sense. I do not hear any concerns with average blood pressure. So sorry to whoever is steering. Is that you, Al? Back down to Level 2. Elevator going down. We are going to skip Grace's advance directive and move on. Again, thank you for your patience. We are going to save this for when Grace is here because she submitted this element, so go on to Row 25, Entry No. 23, I think.

Clem McDonald
Just to clarify, there are a couple variants of advance directive, right? Are we speaking to all of them?

Sarah DeSilvey
I believe there are a lot of considerations in advance directives, especially as they relate to our conversations and what we are building in goals, preferences, and priorities. I do feel like given the fact that we have addressed so much now in USCDI V.4, we can have a really good conversation on advance directives when Grace is with us next week, if that is okay.

Clem McDonald
Yes, that is fine.

Sarah DeSilvey

Wonderful. Next row. Again, I am just trying to move through the Level 2 elements, so we are skipping this one. Oh, this was a reclassification element that I believe Mark submitted that, as part of USCDI V.4, SDOH assessments are moved under health status assessments, and I have not seen any other concern regarding this in any other comments since Steven and I commented. Any concerns for this move? No? It seems to make sense, grouping with like things.

Al Taylor
Sarah, I have sort of a comment, recommendation, or suggestion for the workgroup. When recommending a data element that is in Level 2, I just would ask that the recommendation should address any issues with the existing definition as well as support or not, and if there are any suggestions about change of definition or designation of applicable standards, it ought to be used. I would very highly appreciate that to make sure that it captures your thoughts.

Sarah DeSilvey
Thank you, Al. That does seem important. I do know that there are some thoughts regarding the definition on health status assessment, given its evolving nature. It has changed a lot over the course of the last few years, so we will try. If individuals have comments on how the definition applies given the new elements, that would be really important to include in the recommendation. Thank you. Mark is not here, but Row 26 was the reiteration of last year's IS WG recommendation to include the elements coming out of the Gender Harmony Project. Last year, Gender Harmony came and presented. They were part of our IS WG recommendation last year, and they have been recommended again. There have been comments from our colleagues across the ecosystem in this IS WG draft already about support for that. Any concerns with recommending, again, the gender identity, sex for clinical use, recorded sex and gender, and name to use and pronouns that issued from the work of the Gender Harmony Project?

Steven Lane
I strongly support.

Clem McDonald
Is this elaborate on some other document? Because this is packing a lot into one sentence here.

Sarah DeSilvey
Clem, what happened is Mark condensed the recommendation, which was much more extensively detailed in last year's IS WG recommendation in the HITAC. There is a very extensive comment in last year's IS WG recommendation. We can bring that back up for review.

Clem McDonald
Okay.

Sarah DeSilvey
Hans?

Hans Buitendijk
Yes. Just to clarify, some of it still needs to be published from a standards perspective. That is a reasonable timeline to expect it out. I also want to highlight that this might further help get alignments across jurisdictions

on what is being used for vocabulary around these because we are noticing variations here and there that make it challenging to implement. That would be quite helpful.

Sarah DeSilvey
I think that is noted in the comments. This is, of course, very critical for the health equity objectives as well. So, I hear no concerns with the recommendation of moving these elements from Level 2 into USCDI V.4. All right, next row. There are some subtleties here based on what we have already discussed, and so, these next few elements are going to be… Can we go over to the discussion? Because there is some detailed discussion back and forth between Al, Steven, and Aaron. Let's think about this. This element is abnormal test results, and there is extensive comment in the workgroup discussion on this matter. Does anyone want to lead this conversation, just to figure out what our disposition might be?

Clem McDonald
I thought there was a fairly well defined HL7 list of codes for this item. I do not know if I am missing something.

Hans Buitendijk
I thought that, with the ones that we already included, we covered the discussion around interpretation and the test report date and time particularly, and with the test performed date and time, we were looking at the specimen collected clinically relevant date/time, that effectively, these three have already been addressed, so I am not sure what might be different than what we already discussed.

Sarah DeSilvey
Yes, and that is one way of looking at these, so they could have been included in everything the workgroup led before. Are there any other thoughts on that?

Clem McDonald
This is result interpretation. There is a whole list of codes in HL7 that specify the interpretation in a coded form.

Hans Buitendijk
Agreed. I am unfortunately familiar with Table 78. I thought result interpretation on Row 11 was meant to represent that. That is why. So, it is not disagreeing that it should be in, but effectively, with the comments, we already got it in.

Sarah DeSilvey
Yes. Raj, any thought on whether you are comfortable resolving these, given the recommendations that came from Hung's workgroup?

Steven Lane
I totally disagree with the statement that abnormal flags have less utility. You look at the report, and you read down, and when you see that abnormal flag, you pay attention.

Steven Lane

I completely agree with that statement. Insofar as the abnormal flag contains a critical element, it is very important, and can be used for routing information, and it can also be used to determine how data is displayed to the patient or caregivers. I think this is important for us to bring forward.

Raj Dash
I agree with those comments as well.

Sarah DeSilvey
So, we are hearing a recommendation that is, as noted, necessary, an addition to the work that was done in the laboratory element subgroup.

Hans Buitendijk
I am still confused. It seems that it covers the data set in vocabulary, so perhaps the extended justification can be merged together, but it seems like it is about the same concept.

Steven Lane
Yes, so long as it is included in that result interpretation.

Sarah DeSilvey
Is Hung with us?

Hans Buitendijk
For example, if you look at Row 11 and you go to the result interpretation, the vocabulary that is being referenced in there, it is the same one that is coming from the row in the Level 2 one. If you will, in HL7 V.2 speak, it will go back to Table 78.

Clem McDonald
Hear, hear.

Sarah DeSilvey
Thank you, Hans. Al?

Al Taylor
I just wanted to reiterate that, as I mentioned earlier, this data element is the same data element that is in draft V.4, and so, if the recommendation is to change something that is in that data element, that is what the recommendation should be.

Sarah DeSilvey
So, is it okay to ask Raj, as the person who submitted this, to ensure that the subtleties represented in this element are included in the recommendation for USCDI V.4, as led by Hung's subgroup? Does that sound like an okay disposition to start?

Raj Dash
I think that sounds fine, and the subgroup can get back together. I must admit that I myself am missing the subtlety of what the key controversy is on this.

Sarah DeSilvey
Okay, then perhaps there is none. Let's just say that there is enough commonality that we hope to resolve it in the definitions that the subgroup came up with for the USCDI V.4 elements listed above.

Steven Lane
That sounds great.

Sarah DeSilvey
That sounds like a great disposition. I think we are very, very close to time and going into the public comment. I think there are a few other like things underneath. Raj, you submitted Entries 27, 28, and 29. I think we probably will just need to come back and make sure that the same applies to them, but if they are able to be resolved in the USCDI V.4 comments and definitions above through the work of the subgroup, that would be elegant. If not, we can come back next week and discuss them further. Does that sound good?

Raj Dash
Yes, I think our subgroup should get together because I think we have elements in the spreadsheet that were entered prior to our subgroup meeting, so we just need to get back in sync.

Sarah DeSilvey
Correct, and just reconcile them. That sounds great. And then, we will come back next week and go forward.

Raj Dash
Perfect.

Steven Lane
Sarah, I believe you wanted me to have a moment to comment on what is in Row 47, diagnostic imaging reference.

Sarah DeSilvey
Oh yes, I did. Can you quickly do that? I am so sorry, Steven. My apologies.

Steven Lane
No problem. So, actually, at the request of ONC, I looked into and added the item in Row 47. There is a data element at Level 2 called imaging reference, under diagnostic imaging, which allows for the sharing of the path information necessary to find the image itself in the source system, and there is a very cogent argument for why this should be included to advance the cause of imaging interoperability. We have had some small-group meetings to discuss this and would like to bring this forward with a couple of guest presenters next week.

Sarah DeSilvey
Thank you, Steven, for leading the charge on that. My apologies for not making the subgroup meeting. So, we do have identified guest speakers that we would like to bring back next week if this seems it has been a precedent so far. Any objections to doing so so we can ensure that we can address this opportunity here?

Clem McDonald
No, but along the way, I would like to support Steve's statement.

Steven Lane
Thanks, Clem.

Sarah DeSilvey
So, Steven, the plan is the plan, then.

Steven Lane
Great, and I put as much detail as I could into the spreadsheet for those who want to review this ahead of our discussion.

Sarah DeSilvey
Fantastic. I note that Pooja has commented for the medication Level 2 data elements. NCPDP Education Legislation Task Group will be reviewing those today, and the HL7 Pharmacy Workgroup will be reviewing those on Monday. That is perfect timing for coming back next week with dispositions, hopefully, and recommendations. Thank you so much. Any other final comments? I know we have a few minutes before public comment. Our order has gotten a little disrupted, but I just wanted to make a recommendation. This is just a process thing. Again, please, if you put in the Level 2 common area a comment on a USCDI V.4 element that is addressed above, ensure that those recommendations, justifications, and commentary are included in this section for that USCDI V.4 element so that we can ensure that it is part of the final recommendation. There are a few incidences of that.

And so, next week, we are looking forward to going into advance directives because Grace should be with us, picking up diagnostic imaging, and reviewing some of the other missing Level 2 elements we have yet to address. Any other final comments before we go to public comment. I am just noting we have accomplished a lot today. I know we rarely go to public comment early, but it seems like we might be able to transition.

Public Comment (01:21:32)

Michael Berry
Thanks, Sarah. We are going to open up our meeting today to members of the public. If you are on Zoom and would like to make a comment, please use the raise hand function, which is located on the Zoom toolbar at the bottom of your screen. If you happen to be on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. Let's pause for a moment just to see if any members of the public raise their hand. I am not seeing any hands raised, so I will turn it back to Sarah. Thank you.

IS WG Workplan and Timeline (01:22:06)

Sarah DeSilvey
All right. So, if we go back to the presentation, I really just want to pick up on some of the comments that Hans was making regarding moving from the work we have been doing to our final recommendation. So,

we do have to get that final recommendation going. Naresh and I are drafting the introduction based on precedent from prior IS WG meetings.

I have asked any IS WG members who either did subject matter expert presentations or led subgroups to take a lead on the drafting of those final recommendations because they are really best able to represent some of the shifts in evolution of the elements that we have discussed, so if you are not one of those people and you want to take a lead on any of the commentary in the final recommendation, please send us an email, or you can even just put your name in the spreadsheet and claim that recommendation so that we can ensure collective review of those final recommendations that meet the subtleties and the clarifications that, again, Hans specified that we need to get to. So, if we could start working on that over the course of the next week, that would be wonderful. I think we are heading into our last guest speaker next week, which will be focusing on diagnostic imaging, and resolving some of those final Level 2 elements going forward. Any other questions before we adjourn?

Clem McDonald
Who is the speaker next week?

Sarah DeSilvey
Steven, can you remind us who the speaker is?

Steven Lane
Yes. We are going to be bringing forward multiple speakers from the American College of Radiology, Care Quality, and a radiologist from Mount Sinai in New York.

Clem McDonald
Any DICOM people?

Steven Lane
These are people who work with DICOM. They are not DICOM-specific. If you have a recommendation for someone who works directly with DICOM, I would be happy to reach out to them, discuss this with them, and see if they could add value.

Clem McDonald
I do not know if I do. I will poke around, I think.

Steven Lane
Clem, look at Item Entry 37 on Row 47 and see what you think could be added to that.

Clem McDonald
Thank you.

Sarah DeSilvey
Again, Steven, thank you for taking on that work. It is appreciated.

Steven Lane

My pleasure.

Sarah DeSilvey
All right. I hope you have an understanding of the homework and the objectives of this next phase of work. Naresh, any final comments before we adjourn?

Naresh Sundar Rajan
We have a lot of work to do from these comments, and thanks again for all this feedback. I am looking forward to the discussion in the next session.

Sarah DeSilvey
Again, everyone, thank you so much for the work that was done today and leading up over the prior meetings. I am looking forward to getting our final recommendation set, and we will see you next week.

Adjourn (01:25:15)