Transcript

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

March 26, 2024, 10:00 – 11:30 AM ET

VIRTUAL

MEMBERS IN ATTENDANCE

Sarah DeSilvey, Gravity Project, Co-Chair
Steven (Ike) Eichner, Texas Department of State Health Services, Co-Chair
Pooja Babbrah, Point-of-Care Partners
Shila Blend, North Dakota Health Information Network
Hans Buitendijk, Oracle Health
Keith Campbell, Food and Drug Administration
Christina Caraballo, HIMSS
Grace Cordovano, Enlightening Results
Derek De Young, Epic
Lee Fleisher, University of Pennsylvania Perelman School of Medicine
Hannah Galvin, Cambridge Health Alliance
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Steven Lane, Health Gorilla
Hung Luu, Children's Health
Katrina Miller Parrish, Humana Health Insurance
Alex Mugge (& Traci Archibald), Centers for Medicare & Medicaid Services
Rochelle Prosser, Orchid Healthcare Solutions
Mark Savage, Savage & Savage LLC
Shelly Spiro, Pharmacy Health Information Technology Collaborative
Zeynep Sumer-King, NewYork-Presbyterian
Naresh Sundar Rajan, CyncHealth

MEMBERS NOT IN ATTENDANCE

Ricky Bloomfield, Apple
Medell Briggs-Malonson, UCLA Health
Raj Dash, College of American Pathologists
Jim Jirjis, Centers for Disease Control and Prevention
Anna McCollister, Individual
Aaron Neinstein, Notable
Kikelomo Oshunkentan, Pegasystems
Fillipe Southerland, Yardi Systems, Inc.

ONC STAFF

Seth Pazinski, Director, Strategic Planning & Coordination Division, ONC
Wendy Noboa, Designated Federal Officer, ONC
Sara Armson, Office of Technology, ONC

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

Seth Pazinski
Good morning, everyone, and welcome to the Interoperability Standards Workgroup meeting. I am Seth Pazinski with ONC, and I will be serving as your designated federal officer on behalf of Wendy Noboa. I want to thank everybody for joining today. As a reminder, all the workgroup meetings are open to the public, and public feedback is welcomed during the meeting. There are two ways that members of the public can participate. Those are through the Zoom chat feature throughout the meeting and the opportunity toward the end of the agenda to make verbal comments during our public comment period. I am going to start off our call with a roll call, so when I call your name, please indicate that you are present. I will start with our cochairs. Sarah DeSilvey?

Sarah DeSilvey
Present. Good morning, everyone.

Seth Pazinski
Good morning. Steve Eichner?

Steven Eichner
Good morning.

Seth Pazinski
Good morning. Pooja Babbrah?

Pooja Babbrah
Good morning.

Seth Pazinski
Good morning. Shila Blend?

Shila Blend
Good morning.

Seth Pazinski
Good morning. I did receive a message that Ricky Bloomfield will not be able to make our call today. Medell Briggs-Malonson? Hans Buitendijk?

Hans Buitendijk
Good morning.

Seth Pazinski
Good morning. Keith Campbell?

Keith Campbell
Good morning.

Seth Pazinski
Good morning. Christina Caraballo?

Christina Caraballo
Present.

Seth Pazinski
Grace Cordovano?

Grace Cordovano
Good morning.

Seth Pazinski
Raj Dash? Derek De Young?

Derek De Young
Good morning.

Seth Pazinski
Good morning. Lee Fleisher?

Lee Fleisher
Good morning.

Seth Pazinski
Good morning. Hannah Galvin?

Hannah Galvin
Good morning.

Seth Pazinski
Good morning. Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Seth Pazinski
Good morning. Jim Jirjis? Steven Lane?

Steven Lane
I am here and channeling my inner Ricky in the black T-shirt.

Seth Pazinski
Thank you, Steven. Hung Luu?

Hung S. Luu
Good morning.

Seth Pazinski
Good morning. Anna McCollister? Katrina Miller Parrish?

Katrina Miller Parrish
Good morning.

Seth Pazinski
Aaron Neinstein? I did get a message that Dayo Oshunkentan will not be available today. Rochelle Prosser?

Rochelle Prosser
Present, good morning.

Seth Pazinski
Good morning. Mark Savage?

Mark Savage
Good morning.

Seth Pazinski
Alex Mugge?

Alex Mugge
Good morning.

Seth Pazinski
Good morning. Fil Southerland? Shelly Spiro?

Shelly Spiro
Good morning.

Seth Pazinski
Good morning. Zeynep Sumer-King?

Zeynep Sumer-King
Good morning.

Seth Pazinski
Good morning. Naresh Sundar Rajan?

Naresh Sundar Rajan
Good morning.

Seth Pazinski
Good morning. All right, that completes our roll call. Again, I want to thank everybody, and now, please join me in welcoming Sarah and Ike for their opening remarks.

Opening Remarks (00:03:26)

Sarah DeSilvey
Thank you so much, everyone, for all of your work. Before the meeting kicked off, we were talking about the extensive amount of work that has happened that has taken us to this point addressing some of the elements that were raised next week. I do not want to talk any further. I want to make sure we have plenty of time to do the work today. Ike, anything else to say today?

Steven Eichner
I have nothing to add, except my gratitude to the workgroup for meeting both today and in offline meetings for the week. I am utterly impressed by the amount of thought that has gone into the work you have put forward, and I am really excited to continue the discussion today.

Sarah DeSilvey
This is a workgroup where it is just so tangible how all of our collective expertise from our different perspectives is laid to bear on the task, and I am so, so grateful. So, today, we hope to wrap up our v.5 recommendations, or at least our conversation on that. We want to be working on recommendation requirements. We should be pretty close. We have about an hour for Level 2, and we do need to give it an extensive amount of time because there are some Level 2 elements we have yet to even address, and then, per custom, we will go to public comment at 11:25. So, to transition, we are going to briefly go through some slides. We are going to start with the recommendations that were given a directive for refinement after last week's meeting and then go directly into Level 2. Next slide.

This is our charge. We are doing a good job. So, the overarching charge is to review and provide recommendations on Draft United States Core Data for Interoperability (USCDI) v.5. Again, we are going to say this at the end, but because of the timeline, if all things go as planned, next week would be the final meeting because we want to get the draft recommendations to ONC ahead of the next HITAC meeting. Our charge is to review the data classes and elements from Draft USCDI v.5 that should be considered for the final USCDI v.5 release and evaluate Level 2 data classes and elements not included in USCDI v.5 that should be considered for USCDI v.5. We are already working on crafting the transmittal letter. Again, just as a note, anything that did not require edits is going to go into a bulk statement of approval. Our job here at IS WG in the final recommendations column is to discuss things that are of comment, of note. Mark?

Mark Savage
There is now being dropped into Column M some draft text for the letter itself. Are leads or are all members of the committee supposed to be reviewing that as well, or is that a different or later process?

Sarah DeSilvey
I think that is for now, too. Is Al with us today? Actually, Al is on vacation. I think that is part of the task for today. Seth, is Al away?

Seth Pazinski
Yes, Al is not here. I believe Sara Armson is here.

Sara Armson
Yes, you have got me today, and you are correct.

Sarah DeSilvey
Okay, thank you, Sarah. Mark, did that answer your question?

Mark Savage
That did. Sometimes the recommendations break things up in different ways. They tend to track just one. Thank you, that answers it.

Steven Eichner
Just to clarify, we want to get the transmittal letter put together now so that the full HITAC has more than two days to review it. If we had to meet just the week before HITAC, there would not be sufficient time to get the letter done and into HITAC's hands for them to use it before their meeting. That is the rationale.

Draft USCDI v5 Data Elements Recommendations & Level 2 Data Elements Recommendations (00:07:23)

Sarah DeSilvey
Thank you, Ike, for that helpful clarification. All right, next slide. This is where we are at with our status with the v.5 elements. We did not discuss interpreter needed last time. We placed a comment in there because you will see in our conversation on that concept, we agreed no comment was necessary and that we could move along, so we are going to really touch upon that today. Everything else has been addressed. We want to revisit advance directive, author, and author role today. We also have an update on the orders category, even though it is set to be refined, and again, thank you for all of your work there. So, if it is okay, I would like to proceed to the Google spreadsheet so that we can hit the ground running, start with advance directive, and then go through orders and offer role, and then move to Level 2. Again, I want to thank everybody who worked on the advance directive recommendation in order to get it to where it is right now, so, given the amount of conversation that has happened prior, I hope we are in a spot to be able to approve it as refined. If we can go down, I think advance directive is on… I forget which item it is.

Hans Buitendijk
It is up.

Sara Armson
It is up, sorry about that.

Sarah DeSilvey
No, that is okay. It is hard.

Sara Armson
I was working on my zooms to zoom in.

Sarah DeSilvey
There we go, perfect. Again, part of the homework was to review the work that has been done prior so we can just say aye-aye, but again, we do want to give room for conversation. Hans?

Hans Buitendijk
Actually, on the advance directive, we had a follow-up that is not yet reflected in here. We forwarded it in an email, but I am not sure you were able to create slides around it because it got a little bit tricky. We talked with a smaller group about the name "advance directive," and in that conversation, another aspect came up. We looked at a couple of options, but we wanted to run it by the larger group because there were ambiguities in either direction that were discussed. Mark and Shelly will keep me straight and honest on this, but on the main conversation of the name, there was a consideration that advance directive information was too closely tied to just advance directive, and there is a living will, power of attorney, and other elements that are of interest, not only the narrower definition of advance directive.

One option was to go in the direction of using "health/healthcare directive." It was felt that that was a little bit too far away from a terminology that the community is used to. The other one was "advance healthcare directive," which takes it a little bit further away from "advance directive," but might be too close to it for some. So, we wanted to run it by this group to come up with a conclusion. Is it "healthcare directive" or "advance healthcare directive"? Which is the better term to use here? There was a sense that "advance directive" is too narrow. Mark or Shelly, did I miss anything on that part?

Mark Savage
Hans, if I remember correctly, I think we as a subgroup were leaning toward "healthcare directive," but yes, we wanted to lay out that we had a discussion about both options and wanted everybody to know about both options. That was the balancing point that I think the small group was leaning toward as a data class, "healthcare directive."

Sarah DeSilvey
It makes sense to be naming a class a type. So, if there is a subtype, you do not name the class as one of the children of the type. Steven?

Steven Lane
I guess I am at a little bit of a loss to understand what is wrong with the term "advance" because these are directives that are made in advance of the event that they refer to. I am happy with any of the names and I think the community will figure out what we are referring to, but I do not quite get what is wrong with the word "advance." They are certainly not retrospective directives, and they are certainly not real-time directives. They are made in advance.

Hans Buitendijk
Is it okay to respond, Sarah?

Sarah DeSilvey
Yes. Christina, we will get to you. Hans, if you would not mind responding directly to Steven's question, that would be helpful.

Hans Buitendijk
The concern that was raised was that if you just say "advance directive," it is very much in the definitions that we hear about and in the presentations from Maria Moen, Lisa Nelson, and others. Otherwise, what we understand is that advance directive is very much about giving consent to somebody else to make decisions on behalf of a number of different topics, so the term "advance directive" is used very specifically around that aspect of directives.

Steven Lane
Hans, I think what you are saying is that people have used it as being synonymous with a durable power of attorney for healthcare, but it is not. The words themselves do not say that. Throwing in "healthcare" tells you what domain it is in, which is probably fine also. I do not think taking out "advance" adds clarity, but again, you guys do whatever you want. I think we will figure it out, no matter what we call it.

Hans Buitendijk
As Mark indicated, that is the way we are leaning, and that is why we wanted to bring it back here, to say that there are ambiguities or challenges either way. So, we are comfortable with whatever the group indicates as well, but that is what we wanted to bring up from a context perspective.

Sarah DeSilvey
Christina, do you have insight to lay to bear on this?

Christina Caraballo
Yes. After our call last week, I did reach out to Maria Moen, and she mentioned that during the ONC annual meeting in December, Micky referred to this as "advance healthcare directives," which she strongly supported. So, for what it is worth, "advance healthcare directives" was mentioned by Micky and supported by the SME that we brought in.

Sarah DeSilvey
So, that seems to be inclusive. It is kind of a merging of the recommendations. Mark?

Mark Savage
I just want to note that the small group did know that Micky had said that, and that was a part of our discussion and recommendation.

Hans Buitendijk
Again, the small group is comfortable going either way. It was a leaning. That is it.

Sarah DeSilvey
Grace, I am sure you have thoughts.

Grace Cordovano
There are so many interesting conversations during these meetings, and ONC does a great job with its blogs, and I feel like even this taskforce could come up with short blogs as summaries of our contemplations and conversations, and this would be one of those, where it sounds like a written piece explaining this, our

thought process, how we arrived on it, how there was outreach to Maria, and what Micky said, summarizing all of that so that there is a reference point that can literally be a footnote on whatever the decision is. I think that would be so helpful for transparency, and just showing from a workflow process how much thought goes into making sure we get these as close to right and acceptable as possible.

Sarah DeSilvey
Thank you, Grace. I think that sounds like a great idea. We have a lot to cover today, and this is a naming convention. We have some content things, so if we can have a couple more comments, figure out something to call it, and then move on to the next thing, that would be helpful. Ike?

Steven Eichner
Really quickly, from a patient perspective, is adding the word "healthcare" good or bad for what may end up being in this collection of directives? Is there a thought about what other types of things may end up in this bucket that are on the edges of healthcare and could then get confused? I just want to do a little reality check in that space.

Sarah DeSilvey
That is an important note. Hans?

Hans Buitendijk
I have a quick reaction to that. We talked a little bit about it as well, whether we were thinking about health rather than just healthcare, but given the initial focus that we have, it was felt that that might be making it a little bit too wide, too early. Perhaps in the future, it might be good, but at this point in time, the sense was if you look at the particular examples, which I put in the chat, it seems to be more around the healthcare rather than some of the edges.

Sarah DeSilvey
All right. I am going to have two more comments and then hear the two proposals, and we are going to have a good old-fashioned vote, because it does not sound like anyone has strong feelings on either side. Grace?

Grace Cordovano
I will play devil's advocate here. From the work that I do daily, when you mention "advance directive," it immediately has the connotation of end-of-life care and that you are done, and that is not the case. There is an educational awareness component. From me, working in oncology and as a patient advocate, I feel that there is a benefit in potentially adding "advance healthcare directive" or "advance care directive" as an additional parameter, showing a broader scope, but also, again, an education piece on what we are accomplishing here, and maybe a blog piece to describe what the thought process was.

Sarah DeSilvey
Thank you so much, Grace. That is ever so important. So, can someone distinctly summarize the two options that we have heard so far? Who wants to do that? Then we are going to have a good old-fashioned show of hands.

Steven Eichner

Sarah, before we do that, I want to make sure we did not just hear a third option, which was “advance care directive” as opposed to “healthcare directive.”

Sarah DeSilvey
I think we did. Grace, can we start with healthcare, see how we feel on that one, and see if it needs to be refined? It sounds like you were okay with “healthcare” too. Is that correct?

Grace Cordovano
I did suggest that as a third option, not to complicate matters, but just to see how I could play Switzerland here.

Steven Eichner
Personally, I like “care” as opposed to “healthcare,” but that is my personal perspective.

Sarah DeSilvey
So, again, we all agree on the elements, but we are talking about the naming class, correct?

Hans Buitendijk
Correct. There is an element on the elements on their own, but the name is the main one.

Sarah DeSilvey
So, the three elements we have now are advance directive information as a data class, advance healthcare directive as a data class, and advance care directive as a data class. Is that correct? Am I right?

Mark Savage
And you have heard healthcare directive as a data class.

Sarah DeSilvey
Is that a fourth?

Mark Savage
That is the leaning of the subgroup, but we were happy with both.

Sarah DeSilvey
We need ranked choice voting! My word! So, can we start with the recommendation of the subgroup, which is just healthcare directive as a data class, without “advance”? Is that correct? Can I see a show of hands for that one?

Hans Buitendijk
Oh, “healthcare directive” is right now? Sorry.

Sarah DeSilvey
Yes, “healthcare directive.” I am literally going to count. We have six folks. Thank you so much. And then we have “advance directive information” as a data class, correct? That was the one that was here.

Hans Buitendijk
Correct. That is the starting point.

Sarah DeSilvey
I am just trying to put them in the chat. Can I have a show of hands for "advance directive information"?

Hans Buitendijk
Well, we have consensus on that.

Sarah DeSilvey
That one is pretty straightforward. And then, we have "advance healthcare directive." We have nine. That is going to be a hard one to beat. And then, we have advance "advance care directive."

Grace Cordovano
Sarah, I am a tossup here. I am torn here about "advance care directive." I cannot split my vote. I will not be a point five.

Christina Caraballo
I am struggling on that one, too.

Sarah DeSilvey
Let's make a blog on this one. I did not have time to vote, but it seems like it would not have swayed anything. Regardless, it sounds like, in line with what was stated at the ONC annual meeting, the consensus of the group is "advance healthcare directive." Can we move on? Hans?

Hans Buitendijk
Yes, I agree with that. I want to raise the second part of the conversation that happened. That happened in an interaction with Al Taylor, who is not on the line, and along the lines of some of the other feedback he has given, he indicated that this contains three elements, one of which would be representative of the proposal in USCDI Version 5, an observation that indicates "presence of," and then there is a list of examples. We effectively added two other elements to it in the discussion, unstructured document plan and structured document plan, etc. He indicated that, from USCDI Version 5, since those last two are not Level 2 in the proposal, we should probably make the recommendation actionable to indicate that we want to change the name for the first one, but that for the second and the third, we want to recommend looking at them as future additions that can support why we want to have a data class, but recognize that they would likely not get in because they are not far enough along.

Sarah DeSilvey
And that is how we have done work in the past. It is our job from our perspectives to recognize things that make complete sense. We are going to recommend some things that are ready to go live, and then, the ones that are novel then come back next year, when we refine them.

Hans Buitendijk
If it is okay, then I am going to update the draft text with the decision. Does that work?

Sarah DeSilvey
That sounds great. Can someone answer Katrina's question in the chat? "Does this mean a durable power of attorney (DPOA) could or would not be loaded into this data class?" Any thoughts there?

Hans Buitendijk
It is one of the examples, right?

Sarah DeSilvey
Yes. Katrina, did that answer your question?

Katrina Miller Parrish
Yes, I see it in the examples, but since we are making the data class specifically healthcare, to be separated from legal documents, which is what I was hearing, though again, I may be a little confused at this point, I was wondering if "advance healthcare directives" means we are actually not going to be adding the legal documents to this data class.

Hans Buitendijk
That was not the intent of the proposal.

Katrina Miller Parrish
Okay. I feel like we have gone in the other direction, where advance directives had sort of a level of meaning, and now, the data class title really says that it is healthcare directives. I will just leave it at that. I am a little concerned, but I do not want to hold up time.

Sarah DeSilvey
I am going to let Hannah try to answer that one. Hi, Hannah.

Hannah Galvin
I agree with Katrina. It is a little confusing at face value. Yes, we are going to be defining it, but a lot of current vendors already have some definitions, and I think we do have Derek from Epic on the line, and they call it advance care planning, but the terminology that is used does not have "healthcare" in it, but when you say "advance directive" or "advance care planning," it includes both legal documents, and if you include "healthcare" in the data class, I think it could potentially promote confusion. You have forced people to look at the definition, but I do understand the points that have been made. To Steven's point, I know there are other topics, but I do understand Katrina's point that if you do want to include the legal and financial documents here, there is a little bit of a mismatch.

Sarah DeSilvey
For the sake of time, can I ask whether this conversation makes anyone want to change their vote from "advance healthcare directive" to "advance care directive" and show their hand? For timing, I think that is the only thing we can do, just for the sake of moving on. Do the considerations that Katrina and Hannah raise make anyone want to change their vote? I see Lee raising his hand. I do not think that is enough to sway us, based on the findings of the vote, so are we okay proceeding with "healthcare" and explaining it in the definition? Are we good? Okay. I do want to hear all thoughts involved.

Steven Lane
See the chat, too, Sarah. The chat is saying to leave the non-healthcare, the other legal stuff, out of this, except for Rochelle and Katrina. There is a diversity of opinion.

Sarah DeSilvey
A minority dissent… Are we okay proceeding with it as defined right now? Are there any glaring concerns? Again, I am trying to follow the chat. Hans?

Hans Buitendijk
Again, I want to highlight that I did update the text with the AHD, and that based on the discussion with AI, within the data class, I included the following initial data elements, which is one, and consider for future inclusion.

Sarah DeSilvey
Lovely. Now, I believe we are moving on to orders. Again, thank you, team, for all of your work on the advance directive elements. That is weeks and weeks of all of you laying your expertise to bear. Steven, I believe you were willing to proceed with the conversation on orders.

Steven Lane
Yes, I am happy to represent this. We had a group that met with a lot of good discussion, again, just to highlight that this is a really important advancement in USCDI. Orders get added, but we want to make sure they are added in a way that sets the stage for future success as opposed to trying to boil the entire ocean here. I can just try to work through this so people can understand it, but basically, the idea is that eventually, this should make all orders transmissible so that individual patients have the chance to take their order with them, but we do not feel that the industry is quite ready for everything right out of the gate, so we are proposing some prioritization, starting initially with medications, laboratory, and imaging orders, as these are very well standardized and required in health IT certification, as well as the advance directive orders, acknowledging that with advance directives, there is a lot of complexity.

So, starting with the requirement to make it clear, as we were recently discussing, that an advance directive exists, that it was placed, when, by whom, etc., knowing that, over time, these standards will evolve so the details and/or the documents of that can be shared. There is a desire to add other types of orders over time, such as nursing, therapy, dietary orders, etc., but we are not expecting that that can all be done right up front. We also wanted to highlight that orders do not need to only be sitting in a new orders data class, but this is one of those examples, like others we have been discussing, where there should indeed be a new class called “orders,” but that it should reference specific data elements that also likely exist in other data classes, like the laboratory or medications data classes, etc.

Some orders have very specific order details that need to be added. Obviously, a medication has a dose, a route, a frequency, and some other administration instructions that may not apply to, say, an order for physical therapy, so the idea of specifying those domain-specific data elements within the data classes dedicated to that type of order made sense to us. And then, at the end, in the usage note, we make a point of stating that just because the fact that orders exist is included, the fact that these orders might include all of the details that would be necessary for an ancillary, a provider, or somebody else to carry out the order, we do not presume that including this in USCDI implies support for full end-to-end workflow management.

Over time, that is the goal, that an order could go from Point A to Point B, it could be resulted, the results could go back to the ordering provider, the CC'd providers, the patient, etc., but we know that is not the reality today.

So, this was designed to be a way to move into the space of orders in USCDI v.5 without asking for or demanding things that we think are unrealistic at this point and to lay a foundation for future evolution. So, Hans, Derek, or others that were in the workgroup, would you like to add to that?

Hans Buitendijk
No, I think you covered it all, so I appreciate and support this direction. I have one clarification. Sometimes a question comes up as to why we do not have the workflow as part of USCDI, and it is merely more about the downstream effect of USCDI, which is supported by Fast Healthcare Interoperability Resources (FHIR) US Core and Consolidated Clinical Document Architecture (C-CDA), and as those standards currently exist, they demonstrate that you support USCDI in certification. Those standards do not support workflow management in that sense. That is primarily done using Health Level 7 (HL7) Version 2, National Council for Prescription Drug Programs (NCPDP), etc., a number of different varieties in there, so we want to avoid the interpretation that inclusion of orders would mean FHIR-based order management workflow.

Sarah DeSilvey
Thank you so much for this great, thoughtful draft comment. I hope everyone had a chance to review it because it has been here, and it so thoughtfully addresses our concerns from last week that I would love to proceed after Rochelle's comment. Rochelle?

Rochelle Prosser
Thank you to the group. I support this draft 100% in scaling to size. I think it is going to take time for adoption. Especially last week, we had that long discussion about advance directives and orders. Specifically under ambulances and making sure that for certain specific do-not-resuscitates, it is communicated quite effectively to ensure that we have proper interoperability and communication, so I think that it does need scale. I might say I would like to put that one first because we do not want to do harm to people where they have already made those decisions, but I understand the reality and scope of the conversation and proper communication in saying that it is going to take time to be able to transfer those documents in to a usable form that is communicated using FHIR in all of the current communication language going forward. So, thank you. I agree with this.

Sarah DeSilvey
Thank you so much, Rochelle. Any concerns with the draft of the recommendation? Again, thank you for its thoughtful crafting and addressing where we are now and where we need to go. If there are no concerns, I am going to express sincere thanks for the work of drafting this recommendation. I am very grateful to all of you, and we are now briefly touching base on interpreter needed before we move on. The reason why we are touching base on interpreter needed is because we did not talk about it last time, but when we presented it, it was an element on which everyone agreed without edits, so I wanted to make sure we all agree on that. As part of the formal comment, do we need to edit? Any concerns with a simple "yes" without comment? Okay, we are moving on now to author and author role. Mark, I believe you were taking the lead on that.

Mark Savage
I was. There was no change to the recommendation that we have been discussing. The one addition is to move over from a prior column to Column M some statements that answer a question that ONC asked, both in the Draft v.5 that was issued and in the spreadsheet, and that is sufficient implementation. So, I merely answered the question, but the recommendation has not changed. Those two longer paragraphs that you see are the answer to the question.

Sarah DeSilvey
Thank you so much. There was the question that was posed directly by ONC, so now, the draft recommendation is in direct response to that. Thank you. Any thoughts on author and author role? Hans?

Hans Buitendijk
To clarify, I think we would generally support author being expanded. Currently, it is primarily focusing on the organization, and we can get to the person. Similarly to the discussion around orders, how far can you go? How are the underlying standards actually being used? Around author, I know we will find that the term "author" is typically implied to then mean not only that a provider is the one that actually authored it, but that the patient actually authored it as well, and it can be a reflection of certain aspects, but we want to avoid that implying that USCDI now indicates that the patient is now going to be able to enter data directly using FHIR-based Application Programming Interfaces (APIs).

That would be a bigger step in light of where the industry is at, and therefore, the reflection indicates that this was expressed by the patient and is in there, and it might have been communicated in some manner and then incorporated in and documented somewhere else. I think we just have to be careful that we do not intend to imply that this means that FHIR US Core now is going to be available for patients to directly write into the EHR as the most likely certified health IT. So, that is just for clarification. It does not mean that this is not a good step forward to really start to capture author better and more precisely, and not to prevent that from happening. People are moving in that direction, but it would be a step too far to immediately already imply that now, "everything" in FHIR US Core is available for patient writes.

Sarah DeSilvey
Does someone have a comment? I just want to clarify that that in no way invalidates this recommendation. That is just a statement on where we are at this time, correct? No changes to the recommendation as drafted?

Hans Buitendijk
I am not suggesting a change at this point in time, just awareness, because as part of how FHIR US Core and C-CDA will be further defined, that will be an aspect of making sure there is clarity around that.

Sarah DeSilvey
Wonderful. Rochelle?

Rochelle Prosser
I just wanted some clarification now, and maybe this is an offline question for you, Hans, or any of the other data geeks like myself. Isn't there a timestamp or some type of recorded electronic stamp today of who is authoring these documents currently that we can have? Also, is the issue the paper transference of these

documents into an electronic form so the author stamp becomes the person who is doing the transferring? I just wanted some clarification on this to understand better what the actual main issue is on why we have to clarify this in this instance. I was not part of the group.

Sarah DeSilvey
It looks like Mark has an answer for you.

Mark Savage
In the provenance data class, the author timestamp is already there. I just took a quick peek, and it looks like it has been there from USCDI v.1, so we are looking at a portion of a whole that already exists, if that helps.

Rochelle Prosser
Okay, thank you.

Sarah DeSilvey
Any other further thoughts on author before we move forward? We are going to move forward, and it looks like we can go one row down to author role. It is all rolled up in there, right, Mark?

Mark Savage
Yes, it is the same thing, the same answer to ONC's question. There is no change to the recommendation that the workgroup discussed. It is FHIR, and it is just a "yes, we agree" with ONC's original recommendation.

Sarah DeSilvey
Great. It looks like Hannah has her hand up and Hans has a comment in the chat. Hannah?

Hannah Galvin
I was not part of the workgroup, so I wanted to clarify. Are the author role categories aligned with other role categories that we have across USCDI? It sounds like the role categories of provider, patient, family member…or are those categories specific to this data element? I think it would be helpful if those role categories were standardized, but I just wanted to double-check on that.

Sarah DeSilvey
It looks like Sara Armson is navigating us to that section for the explanation. Mark, you have your hand up as well.

Mark Savage
From my perspective, yes, there is consistency. ONC's definition is broad, but you see reflections in the various FHIR IGs and so forth in the two paragraphs there that they are using the same sort of grouping of examples as in ONC's definition. Others on the line may have more specific information, but I kept finding the same short list in the various places I was looking at, and I think that is the answer to your question, Hannah. Yes, it is tracking other areas.

Sarah DeSilvey

Are we comfortable with that, given ONC's recommendations and examples in the element? Any concerns? I just need to know what we are doing. Hans, do you want to edit the recommendation in order to include your concern? I just want to make sure. Is there something regarding that that you want to get on note in the recommendation?

Hans Buitendijk
At this point in time, I think the recommendation is okay in that regard. I do not think it needs to be refined because as we go through the process, that will become clearer, and it is only going to get a little bit longer than it probably has to be, particularly because in FHIR, the terms "author" and "informer" are both used, and some of the things that we are talking about here as "author" have a high potential to translate into "informer" in FHIR, and I just want to make sure people recognize that the interpretation, and therefore the terminology along the way, might change. Generally, it has been stated that that is fine for USCDI. It is this kind of discrepancy that, at times, can cause confusion as to what the actual scope of USCDI is when it is implemented. That is the reason why I am bringing it up. There will be a translation step that has a high potential of ending up with using "informer" in places where others would use the term "author" for patients.

Sarah DeSilvey
Thank you so much. Does anyone have a more distinct answer for Katrina's question on relevant possible value sets or data sets?

Katrina Miller Parrish
Sarah, I do not need any more explanation for that. That was just following along with Hannah's comment.

Sarah DeSilvey
Fantastic. All right, I am just trying to make sure all the thoughts are involved. Are we okay with proceeding? No edits to the recommendation as drafted, the thoughts that Hans has noted, and noting alignment generally based on the broad examples in ONC's definition? Any concerns? Rochelle?

Rochelle Prosser
To Hans's point, in the near future, there is the possibility of interchanging author and informer, and that may throw complexity into the understanding once we go forward with USCDI v.2 and other versions. Do we want to include something about author versus informer to say where our position is as a workgroup to say we support author or do not support informer, just to add some clarity for the later date under that definition? I do not know whether this is throwing complication, but I can see the issue that Hans has for the potential of confusion in the future, not necessarily now, but for that future.

Sarah DeSilvey
Mark, it looks like you have a response.

Mark Savage
Both are already used, and have been. They are already working their way through, and I think they will work just fine under the broad definition as ONC has proposed it. It will sort itself out if there needs to be any further refinement. That is my sense.

Rochelle Prosser

All right.

Sarah DeSilvey
Is everyone in agreement with that statement and ready to proceed?

Hans Buitendijk
I think that is more of a discussion once we get to the standards based on the note back and forth between Mark and me here. The terms are potentially confusing and yield different contexts of scope, and that is what we always need to be aware of in USCDI because it is supposed to be standards-agnostic. The terms are not mean to reflect what is actually used in a particular standard or multiple standards, and at times, like here, that is going to potentially create confusion or ambiguity on what you think the scope is that USCDI points at versus what the implemented scope is once you actually translate it into the standard and apply further details on intent. It is just an ongoing challenge that we have. This is another example of where that occurs.

Sarah DeSilvey
Thank you so much, Hans. Again, I am going to ask if the considerations and thoughts mean that we need to edit this recommendation and then return next week?

Hans Buitendijk
I would be happy to try, but I am also okay if we move forward. This discussion is part of the record as well, so it clarifies that yes, we just need to look out for that.

Sarah DeSilvey
Okay. Is the workgroup comfortable with that? All right, go team!

Mark Savage
Sarah, can I just be clear? Is the “that” that you mentioned that we are just going forward with it as it is, or that we are coming back with it next week?

Sarah DeSilvey
We are going forward with it as it is. That is the last thing I heard.

Mark Savage
Perfect. I like that.

Sarah DeSilvey
All right. Before we go to Level 2 again, I just want to note that Entry No. 14 has not been discussed. It was just a simple change, and I wanted to make sure that everyone notes that we have not discussed that yet. It was a simple change from a previous USCDI version. I just wanted to make sure everyone was okay because we have literally not talked about it. We keep on skipping over it. Is everyone okay with the change as noted? Rochelle?

Rochelle Prosser
There is a spelling mistake. There is a D instead of an F in “USCDI should reflect.”

Sarah DeSilvey
Yes. But this is an element where it could be a move forward without comment because there is nothing I see in member recommendation to drive us making a specific comment. Am I correct in that? If there is not any concern with this element, it would not necessarily justify us crafting the recommendation, and the spelling would not be an issue. Are we okay with moving this forward as an agreement with the change as written?

Rochelle Prosser
Yes.

Sarah DeSilvey
Does it need any further discussion? Okay, moving on to care plan. I believe that was the first of the Level 2 elements that we wanted to revisit, and it looks like there has been extensive work, again, resolving any of the elements and concerns we had at our last meeting. I hope everyone has had a chance to review it because the recommendation as drafted definitely addresses the minority dissent from the last meeting, and I am so grateful to everyone who participated in this work. Does Mark or someone from that workgroup want to present the summary?

Mark Savage
I am happy to jump in. The item that we took back after the last workgroup discussion under the additional recommendations there was to talk about the name of the data class and the name of the data element. There was consensus among us that we are bringing back to the workgroup to rename the data class to "care plan data class," but to keep the name of the data element as "assessment and plan of treatment." The recognition from people in the field was that it is used way too much across the ecosystem to change that, even if there might be some conceptual reasons for it, so we are coming back and saying we should stick with the additional recommendation to rename it to the care plan data class, but to keep the assessment and plan of treatment data element name, and that would be the narrative summary. Does anybody else from the small group want to add anything? Okay, there you go, Sarah.

Sarah DeSilvey
I just want to say thank you from those of us who have attachments to assessment and plan of care because we work in clinical practice. I am grateful for the acknowledgement, and so grateful for all of this work. Any thoughts on this gorgeous work of consensus? Sorry, I suppose that was a bias by the cochair, who is appreciative. Any thoughts on this prior to moving forward into the next Level 2 element? Thank you so much to the IS WG team and the team that led this drafting, just honoring Steven's comment as well, how this one has been thought of and refined over the years, so I am again very grateful for this. We did not do this on the slide, but the next two elements are all ones that were okay to move along and final recommendations, so I do not think we need to visit them. Dayo is not here today, but she did take a stab at refining the health literacy recommendation that we gave. Hans?

Hans Buitendijk
Thank you, Sarah. On the literacy topic, we have had some discussions within the Electronic Health Record Association (EHRA) as well around how much this is adopted and what we are looking at. We would be looking for a little bit more clarity as to what exactly is being expected. There is a sense that some of the

information that is being looked for is perhaps not being documented in the way that this suggested. What Logical Observation Identifiers Names and Codes (LOINC) codes should we use? Are we looking at actual literacy in a certain level, or are there going to be more questions around the ability to understand, or what way to communicate is best? As we are looking at EHRs, what are they currently capturing? What kind of standards are really around this? Is there a consistent approach to it from an assessment tool perspective?

There was concern that it might not be as clear in that community as to what that would mean, what is out there, and what standards to use because there is not as much familiarity with that and adoption around it. So, from a maturity perspective, there is a sense that this might not be quite ready. Something is moving in the right direction, but it is not clear whether this is already addressing it.

Sarah DeSilvey
Hans, I wonder if you, Dayo, and I can meet offline because the intention is just that this is already included in some sense because health literacy is a domain of reference within Gravity's work that has previously been addressed. It has instruments, value sets, and data elements as recommended and defined within that work. I would not want to confuse implementation, but that was the thought. And then, Gravity would take leadership in ensuring that the ecosystem understands the domains that have been addressed by our work, putting my Gravity hat on.

Hans Buitendijk
That might be helpful to do.

Sarah DeSilvey
Maybe you and I can meet offline to make sure that is very, very clear. The idea is to note that this is an important concept to know that the concept has been addressed within the work of the Social determinants of health (SDOH) elements that were previously within the USCDI and that there is guidance and implementation within Gravity work, and that will be represented within Gravity and hopefully eventually within the Interoperability Standards Advisory (ISA) page update. Maybe we can meet and come back next week. Does that sound good?

Hans Buitendijk
That is fine.

Sarah DeSilvey
Anybody else who wants to join can come join. So, that was health literacy status, and laboratory specimen collection date and time was fairly straightforward, I believe. I do not think there were any further comments on that one, unless I do not understand. It does not look like Aaron Neinstein is here, but with the next one, we were talking allergies and intolerances to substances and food and whether or not it was contained within the previous nonmedication substance elements that we had prior. Without Aaron here to discuss, do we feel like we are ready to address this element right now, given that from ONC's perspective, it was already included? We did have a conversation last week with Shelly and many others discussing the need to add specific nonmedication substance subtypes. How are we feeling about this one? Do we want to have further discussion on it? Again, there are two camps here, one that nonmedication substances are already included, and the other that, although they are already included, they should be refined. Katrina?

Katrina Miller Parrish
It would be great to know the challenges from the nonmedication category. Why do we have to add this one in? I just do not understand that piece. I understand some level of clarity, perhaps, for pharmacists, but I do not really understand why we have the need for this category.

Sarah DeSilvey
That is a little hard because our champion for this one is not here right now, so it is hard to lean into that. Does anyone want to comment on perspectives of why the nonmedication substance element is not meeting the current use case, or should we wait and move on? Keith?

Keith Campbell
Does nonmedication mean a nonactive ingredient? There are lots of things in medications that are not active ingredients, and those are important to know because people can be allergic to them. Two formulations of the same active ingredient medication could be fatal to one person and of no consequence to another. Fatal reactions to incipients are pretty rare. I think they try to get rid of those things, but there are cases where there are allergic reactions to incipient ingredients, preservatives, or other things. My apologies that I have not tracked this one well enough, but that is one of the reasons why RxNorm has a recommendation that you always include the NDC code with something that has been dispensed because RxNorm does not include the inactive ingredients, and we really need something that has a proper representation of these incipients so that we have better understanding of the medications.

Sarah DeSilvey
Thank you, Keith. Shelly is going to have more wisdom on this than I, but I believe nonmedication substance was not going to be contained in the medication at all. Shelly, do you want to help us out here from a pharmacy perspective?

Shelly Spiro
From an allergy standpoint, when we are classifying different types of allergies, they are usually medication, food, and environmental allergies. Those are the most prominent categories. By saying “nonsubstance,” we are not clarifying enough as to how we actually record allergies, so I think having that classification of the different types is important moving forward because they are looked at in different ways in how we talk to people, such as food allergies to peanuts, the different types of nuts, different types of food, such as shellfish, or even down to the different types of food.

We are beginning to identify a much more codified and clear way of defining those types of allergies within our systems as we are talking to patients and communicating with family members, so, having those distinctions outlined in this later version of USCDI that has not been adopted yet, as we see the industry move in that direction of further codifying allergies because they are becoming such an issue and clinical decision support tools are being used for those different allergy classifications, I do not think dumping everything into medications and nonmedications is granular enough.

Steven Eichner
I would agree with that. I also think that there needs to be an additional category. Speaking for myself, I do not have an allergy to a substance, but effectively, I have an allergy to a process. If you hit me with an

intramuscular injection, you are going to do significant damage to my body, but there is no way to tag that in an EHR easily that says to avoid intramuscular injections.

Sarah DeSilvey
Ike, thank you. So, we have substance nonmedication, and the idea is whether we specify underneath that to include different subtypes. Food is one of them. Shelly has given us examples of other elements that are important, so, what I am going to ask of you, Shelly, and I am sorry to assign this, but it is down to the wire, and is if there is consensus on this, it would be helpful, is if individuals would be willing to do a draft specifically supporting food, since that was Aaron's original request from Level 2, and then, possibly looking forward to others with refinement in time. Shelly, would you mind leading that or getting a group to put that in a final rec so we can look at it next week? Are there any willing partners to take leadership on this final recommendation draft?

Shelly Spiro
I would be glad to. It is difficult for me to lead at this time because I have other projects going on, but I would be glad to participate in this. If nobody else is, I guess I will have to do it myself.

Sarah DeSilvey
No, you will not. Who is willing to help? If we agree that this is important, and I hear friends from FDA speaking, such as Keith, and I see friends in the workgroup saying that this is important, can we have a set group of people to help work on a final recommendation for us to review next week? If we just agree to move on, that is fantastic, and it would not require a recommendation… Actually, no, it is a Level 2, so we should still state some kind of recommendation. Rochelle, are you willing to help?

Rochelle Prosser
Yes.

Sarah DeSilvey
Fantastic. And then, we have Hans helping. Thank you, Keith, for all the perspective, and thank you, Hannah and Grace. Lee adds comments.

Sara Armson
I will jump in with the same procedural information that Al was sharing related to advance directive, which is that we can look at Level 2 data elements for refinement and inclusion. If it is a brand-new data element that is not on any of the tabs in USCDI, then it needs to be submitted, and then the recommendation can be that it is submitted and considered in the future for future versions, but not necessarily for Version 5 because there is that submission procedure that we go through. So, looking at the allergies and intolerances and data class in Draft USCDI v.5 , there are four data elements, and just as a reminder, you can make recommendations on refinement of any of those, and then, in the Level 2 category in that data class, there are two data elements, so if you are looking at the big picture about your recommendation, just keep that little procedural limitation that we have in mind.

Sarah DeSilvey
Thank you for saying that so much better than I did, Sara. The only elements in the data class that are Level 2 are substance food and criticality, so if there are other elements outside of substance food, they

would be a submission rather than a recommendation. Rochelle and Shelly, are you raising your hands? Rochelle, do you have thoughts, or are you just willing to help?

Rochelle Prosser
I am willing to help. I forgot to put it down.

Sarah DeSilvey
Fantastic. Shelly?

Shelly Spiro
Yes. I think the way we have it is a progression of where we are going. Those two data elements of criticality and food are natural progressions into further defining allergy intolerance. We have a lot of work to do on allergies and intolerance. It is a whole other area. It is not going to be something that we are going to do and then take away. It is a progression, so, moving it in at this time would be appropriate. Who is leading this group? Because I did not take down anybody's name. It is not going to be me, but I can come up with the recommendation if you want.

Sarah DeSilvey
To be clear, if it is just that we agree, it can be a very simple recommendation, "We agree with adding substance food as a Level 2 data class at this time." Is that all we are saying?

Rochelle Prosser
I am not sure. Is it substance food?

Sarah DeSilvey
If that is all we are saying, we can just move on.

Rochelle Prosser
Is it substance food? Because I thought I heard a secondary one to say the nonmedical additives in medication, the preservatives, so I just wanted clarification on that. Is it just food, or is it the nonmedication ingredients as well?

Sarah DeSilvey
There are two options here. If we want to make a recommendation with just the Level 2 element of substance food as an existing Level 2, that is fairly straightforward. If we want to lean into some of the comments in the chat and move forward with talking about other refinements in time or do a submission that would then cycle back through the levels and be eligible for USCDI in the future, we have that option as well. Mark?

Mark Savage
Just to ground your question, I come back to the definition that ONC has got at Level 2: Common food substances, substances, and allergens that can cause harmful or undesirable physiological responses when exposed to the substance or the substance is consumed. It seems to me that that is pretty inclusive of the conversations that we have just been having.

Shelly Spiro
This is Shelly. I am going to agree with that, Mark, and I think that that is the main portion. In the future, I see a much more granular list as people begin to want to identify different types of allergy and allergy information. Adding food makes a lot of sense to me because, as we are working with our patients, food allergies is one of the questions that is asked, and it is highly needed to be shared, so I have no problem. Technically, it is a nonmedication, but other nonmedications can be environmental, latex, or soaps, so there are many other nonmedical substances. I think with the way we are going in the classification as ONC moves it up to the levels that it needs to be, it is an appropriate one to be there. I am all for recommending that data element moving forward, and if we do not need a group to decide that, I am fine with that too.

Sarah DeSilvey
The one thing is that the addition of food will allow for more specificity in the current substance nonmedication class because food will be able to be represented in the food class, and that is of note. With the only USCDI element being substance nonmedication, there are some food examples in that class that may need refinement. Keith, do you have any final thoughts before we move on?

Keith Campbell
I am okay. There will be challenges down the road that we have to deal with. So, we went from an evolution of allergies in the medical chart that originally were supposed to be Type 2 hypersensitivity reactions, such as anaphylaxis, and then, it said, “Oh, no, this causes me stomach upset,” so we went to a more inclusive definition, and now we are trying to narrow it by saying foods, but foods are often medicines, and if you are trying to create a categorization, you are going to find problems on the edge. In terms of improving it and kicking the problem down the road, I do not think we can solve it here. We do not have that power over the industry to say that everybody must use this in an absolutely consistent way, so I think that it essentially does no harm, but then people will say, “Oh, I am taking this as a medication by my naturopath,” but is it a food or a med? I do not know.

Sarah DeSilvey
I want to acknowledge your wisdom and expertise in this area and just make sure that we leave space for crafting a thoughtful recommendation that includes those concerns if we want to. Do we feel like we use this space to give perspective like that implementation? Do we feel like we want to do that at this time, or do we want to just say to add substance food without comment? Are we good to go? All thoughts and wisdom are acknowledged. Shelly, we saved you leading a workgroup you did not have time for.

Shelly Spiro
Thank you, thank you.

Sarah DeSilvey
We do not have a ton of time. We have 11 more minutes before public comment. It looks like we were just refining the family health history recommendation. I do want to get to the extensive list of Level 2 elements we have not discussed yet if I can. This is an example of what we would put under substance food. It is fairly straightforward. Any conversation on family health history? It was discussed prior. Okay, I think we are good to move along if that is so straightforward, and then, I think we are going into new elements. We have a few sets in demographics, correct? Or was health insurance information the next one? I am trying to follow the slides. It looks like health insurance information is the next entry. Again, this was presented

and championed by Aaron, who is not here today. I am of a mind to hold on it and try to get him here next week to discuss. I do want to note that Pooja asked us to hold on medications until she was here, and she is here, so I am trying to get to some of those elements below if possible. Mark?

Mark Savage
If my memory is correct, I just wanted to add that I think the workgroup also recommended this last year. It is pretty critical when you are looking at issues of value-based payment to have the basic data about health insurance information. That is a historical point that I think provides support for moving forward, but this may not be the day.

Sarah DeSilvey
What you are saying is that although it is novel, it has resurfaced, and so, we could just recycle our recommendation from prior. It is hard not to acknowledge that this is critical information. Shelly?

Shelly Spiro
I know from a pharmacy perspective, health information is extremely critical for what we do within pharmacy eligibility, both from a clinical standpoint and from a dispensing standpoint, so I am all in favor of health insurance information being expanded.

Sarah DeSilvey
Would folks on the call be willing to have us pull forward last year's recommendation for review, and then we can place it in the member recommendation and review it prior to next week?

Mark Savage
Sarah, I am looking for that as we speak, and I will drop it in in a few seconds.

Sarah DeSilvey
I knew you were. Thank you, Mark, for being a longtime collaborator and a mind reader. Derek?

Derek De Young
I have one thing to note on this. I am fully supportive that this is critical information. I work with health plans day in and day out, and I know how important some of this is to reduce administrative burden and all that. The thing that I worry about and struggle with in this space is just the lack of standards around some of the plan identifiers. If you are talking about having usable interoperability of driving automation using this functionality and it is not just the name of a health plan that is potentially just whatever one health system names that health plan in their EHR compared to what another health system names that health plan in a different EHR, I think there is a lack of national identifiers for health plans in general, which will make this tricky to make it operational from an implementer's standpoint.

There are some standards out there, like the NAIC numbers, which are just an identifier for not even health insurance, just insurance providers in general, but at least Epic EHRs do not put that in their system. Most identifiers are really clearinghouse IDs, but depending on your clearinghouse, those are going to be different from health system to health system, so there are some challenges with this one. That is not to say it is not important, I think it is very important, but I just wanted to make sure some of those challenges were at least talked through.

Sarah DeSilvey
Thank you, Derek. I am wondering if our recommendation from last year included those thoughts on implementation. That is usually the kind of nuance that we represent in our transmittal letter and final recommendation. I see Katrina echoing what you are saying, Derek. I think the action item is to review last year's recommendation, see if it includes those comments, and possibly recommend a first set based on concerns, then come back next week and discuss further. Does that seem fair?

Derek De Young
Yes. One of the other things that is tricky is that this one toes the line between treatment, payment, and operations use cases under the Health Insurance Portability and Accountability Act (HIPAA) as well, which I am not sure what our stance is on that with USCDI, since I am new here, but this one can toe that line depending on what that is. The other thought process is that the health systems are not necessarily the source of truth for this information. They may document it, but if you are pulling this information from a different health system and they have not been at that other health system for over a year, the information you would be getting is out of date and may not even be accurate anymore. So, there are a number of challenges in this space. I think payers have a real opportunity to play a big part in this as well.

Sarah DeSilvey
Mark?

Mark Savage
I have a quick clarification. I did not find it in 2023, I found it in 2022. I see we have 10 minutes left today. I will drop it in, and maybe people can look at it, if this is your pleasure, Sarah and Ike. People can look at it, and we can come back to it next week, but I have found it from 2022, and will drop it in.

Sarah DeSilvey
Thank you so much. We have a couple minutes left. Christina, you are here, and we want to hear about the maternal SDOH note. Pooja, are you ready to talk about the medication administration element, or should we hold until next week?

Pooja Babbrah
No, we can talk about it. I do not know if we want to start with the other one. I will be here next week. I know Shelly and I went back and forth with Al, and I see Shelly raising her hand, so I am wondering if we should wait until next week, when Al is back. Shelly may agree or disagree.

Shelly Spiro
I agree with waiting for Al, but am concerned that it says "medication administration," and it is supposed to be "medication administration route." That was what was confusing to me when we were talking to Al, until I went back and looked at Level 2, and it does say "medication administration route." It is not that broader medication administration, it is the route, but we already have route in the medication list, so that is what I needed Al to clarify, and we did not get that far.

Sarah DeSilvey
Okay, that is confusing. Let's just hold on that one.

Pooja Babbrah
Yes, let's wait until Al gets back, because we were kind of going back and forth over email.

Sarah DeSilvey
Route is Entry No. 5, correct?

Shelly Spiro
That is what is in Level 2.

Pooja Babbrah
No, route is an original one, right? I am not in the spreadsheet, sorry.

Sara Armson
It is a data element in direct USCDI v.5 for route. It was actually added in v.4. On Level 2, there is medication administration and medication administration route. It looks like we will be looking at all three of those, and the names and the definitions are part of this review.

Sarah DeSilvey
Okay, so the action in there is to hold for this week.

Pooja Babbrah
Yes, let's get Al.

Sarah DeSilvey
We will see where we want to land. Again, it is the point of the IS WG to raise things you feel like are important, so if we do not feel like this represents something you all feel is important, we can hold. We are almost at time. Mark, do you have a thought before we go? We will try to briefly touch upon Christina's idea before we go to public comment.

Mark Savage
Sorry, I forgot to lower my hand from the previous time. Nothing from me.

Sarah DeSilvey
Okay. So, we have PMO addressed partly in what is no longer the ADI element above. Christina, can you just add context for the entry on the maternal SDOH note.

Christina Caraballo
Perfect, yes, and I realize I have about 60 seconds before we go to public comment, so I am going to be quick and just get a general sense of the workgroup's feel on this. I did want to bring the maternal social determinants of health note data element into Version 5 as our recommendation. I think this is one of the very high-impact data elements that is being presented. I highly recommend that the workgroup look at Aisha Manuel's submission from the Center for Black Women's Excellence. She did a really robust submission on this that gave us excellent talking points. I think the big thing on this data element is that

right now, the US maternal mortality rate is the highest of any developed nation, with more than double the rate of our peer countries.

We also have a major health equity, with maternal health and mortality rates affecting mostly African-American and Alaskan Native/Indigenous American women, so when we look at ONC's priority on USCDI advancing health data needs for providing equitable care for underserved communities, this one really stands out to me as a priority. It also aligns with the White House's Blueprint for Addressing the Maternal Health Crisis and the recent Black Maternal Health Omnibus Act. So, I am happy to write a final recommendation and put some of the high-impact needs in this under our recommendation for context, but I would love to hear what others think.

Sarah DeSilvey
It is such a critical element. Thank you for giving us the context. If you can create a draft recommendation, we will come back and talk about it next week. We are ready to move so many elements forward that we can fit into these ones. I do want to note that I believe Aisha presented to IS WG two years ago on maternal health equity as a critical use case as part of Gravity's presentation to IS WG in April of 2022. There is a really lovely presentation there. Aisha was a member of the team at Gravity as a maternal health equity specialist at that time, so maybe we can make sure we cycle that back down for everybody's review as well. I do want to make sure we go to public comment. Thank you for your patience. I really want to make sure we get to these Level 2 elements. The good thing is we are moving things along, so we can start to go forward into Level 2. I think we are ready to go to public comment, Seth, and I do want to note that if we have not discussed a Level 2 element for the sake of time, if folks can start leading on recommendations and draft so that we can review those, that would be great. Seth?

Public Comment (01:24:44)

Seth Pazinski
All right, thanks, Sarah. So, we are going to move into our public comment period of the agenda. If you are on the Zoom and would like to make a comment, please use the raise hand feature, which is located on the Zoom toolbar at the bottom of your screen. If you are participating by phone only today, you can press *9 to raise your hand. Once called upon, press *6 to mute and unmute your line. We will just pause here and give folks a few seconds to queue up. Okay, we have no comments on the line, and I am not seeing any hands raised, so I will turn it back to Sarah and Ike to close us out.

Sarah DeSilvey
All right, can we go to the next slide, please? This is what Ike and I were laying the ground for. We are trying to review the final transmittal letter next week, reviewing the actual content. I want to restate what I just stated. If you were taking authorship and ownership for a Level 2 element and there is no recommendation in that column yet or it is not contained in a recommendation from above, like, for instance, portable medical orders, which might be contained within the advance healthcare directive data class and submission, please take the lead on drafting that final recommendation because we are down the wire, and it is easier to review a final recommendation that is already started as opposed to having discussion, and we just do not have time. So, if you care about one of your Level 2 elements and you brought that forward, please take leadership in putting content for review in the final recommendation section, and we will hit the ground running next week. Again, the hope is to get our content and a rough approach for the transmittal letter settled in order to get it over to HITAC in time for the in-person April 11th meeting. Ike?

Steven Eichner
I just reemphasize everything you said. I do not think there is going to be a problem getting the letter to HITAC in time. Our goal with them is to try to wrap things up next week so we do not have to have the April 9th meeting, which would make it a little tight to get a letter to HITAC.

Sarah DeSilvey
Thank you so much, and thank all of you. So much work happened over the course of the last months, but especially the last few weeks, drafting those final recommendations. Thank you, Sara, for assisting and being a guide while Al was away. I think we are ready to adjourn on time. Thank you, friends.

Mark Savage
Thanks, everybody. Bye.

Adjourn (01:27:50)

QUESTIONS AND COMMENTS RECEIVED DURING PUBLIC COMMENT
No comments were received during public comment.

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT
Grace Cordovano: +100

Rochelle Prosser: AGREE

Katrina Miller Parrish: Why Advanced Health care directives instead of just, the usual advanced directives?

Katrina Miller Parrish: What does the "health care" add?

Hans Buitendijk: Advance Directives has for many a more narrow meaning and is in the list of examples only one of a number: "Examples of ADI include: Advance Directives, Durable Medical Power of Attorney, Living Will, and Personal Advance Care Plan.""

Rochelle Prosser: It explains more that just the legal terms but adds broader context to healthcare decisions

Mark Savage: From patient perspective, Advance Directive does not distinguish between healthcare and financial planning, etc.--so I think it definitely helps patients know.

Hans Buitendijk: @Grace : The reason you raised was part of possibly considering just Healthcare Directives as it does not give that sense of end of life only.

Pooja Babbrah: can we put them in the chat?

Pooja Babbrah: We definitely need a blog on this one :-)

Grace Cordovano: I'm in

Rochelle Prosser: Me too!

Grace Cordovano: @ONC: can task forces/workgroups have blogs?

Rochelle Prosser: I think we can summarize after publication in a post...maybe? Asking for clarification.

Katrina Miller Parrish: Does this mean a DPOA could or would not be loaded into this data class?

Grace Cordovano: No

Rochelle Prosser: No we are adding them in

Steven Lane: Do we have time to go this deep on this topic?

Shelly Spiro: Not sure what legal document are concerning because lawyers create legal healthcare decisions such as power of attorney to make healthcare decisions.

Rochelle Prosser: NO

Steven Lane: +1 Keith

Pooja Babbrah: Agree on the non-medical legal documents - should not be included

Grace Cordovano: Legal and financial documents are ultimately tied to clinical/health decisions, ability of an individual to make decisions about their care, impact of end of life, active death, and death.

Katrina Miller Parrish: I am still concerned but will be minority

Rochelle Prosser: Minority discent

Rochelle Prosser: LOL

Rochelle Prosser: Yes to proceed

Katrina Miller Parrish: Appreciate discussion, will just need clear definition.

Rochelle Prosser: +1Grace

Katrina Miller Parrish: Agree Grace, just need that clear in the description since we are refining the name.

Grace Cordovano: Great points raised Katrina and the rich discussions here support us putting clarity into a blog.

Katrina Miller Parrish: 👍

Steven Lane: 🙏

Mark Savage: 🙏

Mark Savage: To Hans' comment, fortunately ONC's definition of Author is broad and does not specify how, just who.

Hans Buitendijk: Since the definition is so broad it is much easily interpreted to also assume that means direct writes are in scope.

Rochelle Prosser: Thank - you Hans

Katrina Miller Parrish: That was my question regarding the "codeset" for this element.

Rochelle Prosser: Author verses Informer is the issue. Now I understand the issue.

Rochelle Prosser: BUt isn't ONC very clear on the roles under the examples?

Hans Buitendijk: Not really as they are not bound and specific to the terminology used in the standards. USCDI is standards agnostic.

Mark Savage: Both author and performer are already present and used.

Hans Buitendijk: FHIR actually uses "agent" of which author and informer are specific values. The general term is not author.

Rochelle Prosser: Can we put a definition caution note?

Rochelle Prosser: +1 HANS

Steven Lane: So exciting seeing us move these long requested data elements forward for (another year of) inclusion in the WG's recommendations to HITAC and ONC.

Pooja Babbrah: +1 steven

Steven Lane: Thank you, Mark and team!!

Rochelle Prosser: +1Steven

Katrina Miller Parrish: Great job small group!!

Rochelle Prosser: great job

Christina Caraballo: Looks great! Thank you!

Mark Savage: +100 @Steven

Katrina Miller Parrish: Non-medication includes food and other substances as far as I understand

Katrina Miller Parrish: The question is whether to pull out food. right?

Hannah K. Galvin: I also thought this was food

Katrina Miller Parrish: Shelly!

Grace Cordovano: From a patient safety standpoint, any non-medication allergen that may cause anaphylaxis, significant physical symptoms and harm need to be recorded here.

Rochelle Prosser: there should be a sub category or Sub class to call out what the issue is within the allergy for greater communication

Rochelle Prosser: Me

Hans Buitendijk: I can help.

Grace Cordovano: I can help

Steven Lane: I react to sulphured dried apricots but not to sulfa medications. This is a common situation.

Rochelle Prosser: Katrina?

Katrina Miller Parrish: I am fine with that

Katrina Miller Parrish: If I am the holdout

Katrina Miller Parrish: Is this a subcategory under non-med?

Mark Savage: Good to go as is.

Pooja Babbrah: +1 shelly

Pooja Babbrah: this is really important information

Pooja Babbrah: yes

Hans Buitendijk: On Medicare Patient Identifier, that is actually covered in USCDI already (Member Identifier).

Shila Blend: +1 This is important

Katrina Miller Parrish: Agreed! Maybe start with Payer and Policy # and coverage period? Happy to review last year's

Rochelle Prosser: +1 Christina

Mark Savage: Re Health Insurance Information, not as targeted a recommendation as I had thought. May need a little reflection before next week?

Mark Savage: @Christina, I can help if needed. Asha is great!

Christina Caraballo: @Mark - Great!

Rochelle Prosser: add me in Christina

Katrina Miller Parrish: Thank you!!

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

RESOURCES

IS WG Webpage
IS WG - March 26, 2024, Meeting Webpage

Transcript reviewed and approved by Wendy Noboa, HITAC DFO, on 4/4/2024