ONC | HealthIT ADVISORY COMMITTEE

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTEROPERABILITY STANDARDS WORK GROUP MEETING

April 2, 2024, 10:00 – 11:30 AM ET

VIRTUAL

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

MEMBERS IN ATTENDANCE

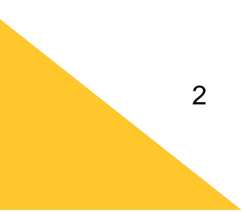
Sarah DeSilvey, Gravity Project, Co-Chair
Steven (Ike) Eichner, Texas Department of State Health Services, Co-Chair
Pooja Babbrah, Point-of-Care Partners
Shila Blend, North Dakota Health Information Network
Ricky Bloomfield, Apple
Medell Briggs-Malonson, UCLA Health
Hans Buitendijk, Oracle Health
Keith Campbell, Food and Drug Administration
Christina Caraballo, HIMSS
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
Jim Jirjis, Centers for Disease Control and Prevention
Steven Lane, Health Gorilla
Hung Luu, Children's Health
Katrina Miller Parrish, Humana Health Insurance
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

Grace Cordovano, Enlightening Results
Raj Dash, College of American Pathologists
Anna McCollister, Individual
Alex Mugge (absent), Joel Andress (alternate present), Centers for Medicare & Medicaid Services
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
Al Taylor, Office of Technology, ONC



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

Seth Pazinski
Hello. Good morning, everyone. Welcome to the Interoperability Standards Working Group. Likely our last work group, at least for this charge on United States Core Data for Interoperability (USCDI) Draft Version 5. I am Seth Pazinski with ONC and I will be your designated federal officer for today's call on behalf of Wendy Noboa. I want to remind everyone that all work group meetings are open to the public and we welcome public feedback throughout. Members of the public can type comments in the Zoom chat feature throughout the meeting or make verbal comments during the public comment period that is scheduled towards the end of our agenda for today. I will start with roll call of the work group members. When I call your name, if you could please indicate that you are present. I will start with our co-chairs. Sarah DeSilvey?

Sarah DeSilvey
Present. Good morning.

Seth Pazinski
Thank you. Good morning. Steven Eichner?

Steven Eichner
Good morning!

Seth Pazinski
Good morning. Pooja Babbrah.

Pooja Babbrah
Good morning.

Seth Pazinski
Good morning. Shila Blend. Ricky Bloomfield.

Ricky Bloomfield
Good morning. I am here.

Seth Pazinski
Good morning. Medell Briggs-Malonson

Medell Briggs-Malonson
Good morning, everyone.

Seth Pazinski
Good morning, everyone. Hans Buitendijk.

Hans Buitendijk
Good morning.

Seth Pazinski
Good morning. Keith Campbell.

Keith Campbell
Good morning.

Seth Pazinski
Good morning. Christina Caraballo.

Christina Caraballo
Good morning.

Seth Pazinski
Good morning. Grace Cordovano. 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. Raj Godavarthi.

Rajesh Godavarthi
Good morning.

Seth Pazinski
Good morning. Jim Jirjis.

Jim Jirjis
Present.

Seth Pazinski
Steven Lane.

Steven Lane
Good morning.

Seth Pazinski
Good morning. Hung Luu.

Hung Luu
Good morning.

Seth Pazinski
Good morning. Anna McCollister. Katrina Miller Parrish

Katrina Miller Parrish
Good morning.

Seth Pazinski
Good morning. Aaron Neinstein. I did get a message that Dayo will not be able to make today's call. Rochelle Prosser?

Rochelle Prosser
Good morning.

Seth Pazinski
Good morning. Mark Savage.

Mark Savage
Good morning.

Seth Pazinski
Joel Andress.

Joel Andress
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
Alex Mugge. All right. That completes our roll call. Thank you again and please join me in welcoming Sarah and Ike with their opening remarks.

Opening Remarks (00:03:30)

Sarah DeSilvey
Good morning, everybody. We have a lot to do today so my primary opening remark is thank you for all of the work done that I can see was done on the recommendations over the last week. You can see, our agenda today is leaning into the Level 2 data elements and trying to give them due diligence and just review what we have to transmit over to HITAC in preparation for our April 11th meeting, understanding we can call back and return 9th of needed. Anything to add, dear Ike, copilot?

Steven Eichner
No, ma'am. I think you did a beautiful job, as always. I do want to extend my gratitude to the work group members for all of the excellent work that you all have done thus far. We can see the end of the project and hopefully we get this stuff done today and ready for HITAC. Thank you all for your contributions.

Level 2 Data Elements Recommendations (00:04:30)

Sarah DeSilvey
Thank you so much, Ike. It is a pleasure to work with Ike. He is a great co-chair. We are changing our order a little bit in our meeting today. You can see we are going straight to Level 2. Next slide. Next slide. This is the charge. It is to review and provide recommendations on draft USCDI v.5. This first part of the charge is the specific charge, which is to make sure that the IS WG reviews and provides recommendations on draft USCDI v.5. I am grateful for all of the leadership and expertise that allowed us to complete this element. We are just refining words now in the transmittal letter. We do want to make sure that we spend most of the day today looking at those Level 2 data classes and making sure that we give them review to elevate them from Level 2 into draft USCDI v.5 as this is part of our charge for IS WG.

We will spend a couple moments going through the slides of the Level 2 elements and then go straight to the ShareDrive, to the Google document, to get…yes, Hans, we are going to try to get to the general process elements at the end of the Level 2 conversation. That was the way we thought we might get to it, even though it is not on the agenda. My apologies. Next slide. Some of the elements have been addressed and we are just working on refining words. I do want to note that Dayo and Hans and I met to refine some of the wording on health literacy status and we will review that. We have to finish our commentary or review of the substance food element, review and touch upon the patient demographic elements that are in there. Some of them align with the gender harmony presentation our SMEs gave prior.

I do want to note that for the sake of time…again, knowing that we need to get something to the HITAC chairs, which is Medell on the call, prior to the end of the week, that we asked all of you to lean in and craft proposed recommendations just so we can hit the ground running. When we go to the spreadsheet, you can see those there. Next slide. We briefly touched base on health insurance information in the last meeting. Thank you, Mark, for getting our prior recommendations from prior IS WG meetings there. We ever so briefly touched base on maternal Social Determinants of Health (SDOH) notes. Thank you, Christina and

Mark, for leaning in on recommendations. They are bringing back some expert guidance we have in the meeting prior. We briefly touched base on medication administration. We have yet to touch base on medical prescribed code. I think there is one more slide, Level 2 elements. Correct? Yes. We have one more. Next slide.

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I think this is it. Yes. This is the device use, signature, assessment, plan, and treatment. There is a lot of correlating elements to other elements on the currently in discussion. You see correlates between assessment and planning treatment and the care plan revisions. Hoping to synthesize as many of these as we possibly can in order to complete our work today. I believe this, closing with the facility address, is the last. You can see we have a lot of things we have yet to discuss. Luckily, some of them are things we have discussed prior in IS WG meetings. I am grateful, even if we do not have Alex on the call, I see we do have some CMS colleagues on the call. When it comes to elements that CMS elevated we can lean into them for support.

Ready to switch to the share dock so we can start going. If we can start at the top of the Level 2 elements in general just to refresh ourselves that would be great. Fantastic. With the expectation that having addressed all the USCDI v.5 elements, we are in finetuning stage for those. Yes. Luckily, care plan was sufficiently addressed, I believe, and elegantly resolved in a lot of meetings offline. This Level 2 element, I think we are okay to skip if everyone agrees. Moving on to the next. I do not think I am wrong on that. Health literacy status. There is an update here, if we can go to the final recommendation page, Dayo and I realized in our summary recommendation we confused the system a little bit because what we were wanting to lean in to state, which is a guidance for centering the existing SDOH USCDI elements.

You see there is a revision here to the recommendation. Instead of recommending that health literacy be an additional element, just recommending that it is highlighted as one of the domains the Gravity project has already addressed and so therefore conceptually and with supporting standards, they are already contained within the SDOH screening assessments, SDOH goals, SDOH conditions, and SDOH interventions value sets. Updating USCDI with Gravity addressed domains and supporting implementors with Interoperability Standards Advisory (ISA) updates, it really is meeting the goal of health literacy in the submission from Dayo that she elevated. Does that make sense? We had stated that we recommended adding it as a unique element and we realized that was a little bit confusing because it is contained within the Gravity domain so we revisited that over the course of last week. Mark?

Mark Savage

It does make sense to me to not say that it is being added since it is already there. None of the domains themselves are listed separately and USCDI is just the four SDOH data elements. I am wondering if this is actually a more global recommendation that all domains should be somehow listed separately or if the existing approach, which was just to list the four SDOH data elements, is sufficient and this is not needed. I may be a little confused. I am sorry.

Sarah DeSilvey

My apologies. We can clarify it. The recommendation we got from our colleagues was given the fact the original submission from the submission from Gravity does not contain updated domains, it confuses implementers regarding what is contained within the elements of reference. If annually we can update the domains in that submission with what has been addressed, it would assist in understanding what is

supported by each of the SDOH elements. As you are aware, because you all tracked that for Gravity a long time ago, that was long before and certainly the 19 domains that Gravity has addressed that includes guidance across all of those four activities are not up to date. It is really just updating the submission itself so that I includes the additional domains have not been addressed and continuing our work to support implementation with ISA. Is that helpful?

Mark Savage
Yes. It may be targeted to health literacy here but it sounds like a global recommendation.

Sarah DeSilvey
Exactly. That is why it is an Implementation Guide (IG) and not a specific call out. It is an example of a domain that would be included in that process.

Mark Savage
Thank you.

Sarah DeSilvey
Hans?

Hans Buitendijk
Thank you, Sarah. I am not sure I am completely understanding, based on the conversation, we had and what we are trying to achieve. I was understanding that in USCDI version three we have the variety of the four main areas. Within those is health literacy, element codes, and other instruments are very specific ones. Depending on the system to be certified, Health Information Technology (HIT), a general Electronic Health Record (EHR), a specialty EHR, there may be different focus appropriate to support specific instruments that are listed in the Gravity Implantation Guide or potentially other ones as well that are appropriate in that space. USCDI version three provided a framework and that the focus here was more to help clarify in ISA and other places that, "Hey, this is a set that Gravity has worked on that can be considered in the existing four main areas that are already in USCDI." We want to be careful in USCDI proper, if you will, to not get too specific, certainly at this point in time. Is it appropriate for every certified health IT to support everything that is explicitly listed.

The four categories overall provide a framework but are we getting too specific with line codes and otherwise that may not be appropriate for all health IT that would like to be certified but certainly needs to be considered and is an option to be included to support SDOH in general.

Sarah DeSilvey
It looks like Al is raising his hand. Hans, that was the intention of this recommendation as reframed so if it does not meet that intention, anyone is welcome to weigh in. Medell?

Hans Buitendijk
Sorry, just to clarify what it is. It is that the SDOH intervention the USCDI is to add. That is, I think, the part where it is confusing as to how much is actually in USCDI proper versus the other parts, the last sentence, IS WG furthermore supports, I thought it was the intent that that is the primary thing that we wanted to achieve to have that transparency and clarity but not necessarily by exclusively enumerating in USCDI,

which I think is also in line with Mark's comments that he was just making. That is where **[inaudible - crosstalk] [00:14:56]**…

Sarah DeSilvey

I think we agreed in principle not to call out specific domains of reference but to ensure that in the submission…I think Al can help here because I am trying to integrate ONC's guidance on this. Just to call out the domains that have been addressed and could possibly be contained within the SDOH elements and ensure that ISA is updated on a regular basis. However, we need to phrase that to achieve that end. Medell? I want to make sure I center you.

Medell Briggs-Malonson

Thank you, Sarah. Thank you already for all of the comments on this because I also had some questions of clarification, especially before Al jumps in. One of the things I think is very important, especially as we continue to transform into a country in which addressing all the social drivers of health directly from our EHRs are so incredibly important. Not only are they important for patient care but they are important from a regulatory standpoint, as we know. Coming down from CMS, joint commission, and numerous other state regulatory entities. I too was trying to understand how we are trying to structure this, because I hear one piece of saying, "Of course, our standard SDOH standards, they have these elements but they are not as explicitly defined and they also need to be updated." Are we saying that what we are recommending is ensuring that the current pillars that are within the SDOH standards are updated, and also updated continuously, in order to address the needs of all certified health IT as well as entities we are using it?

Just wanted to make sure we are all very clear because some of these domains also need to be directly taken out just due to some of the extra levels of complexity and what we are starting to move towards also in terms of using data to really drive healthy equity and justice. Yet also, we want to have the minimum standards that of course are included in the USCDI so that everyone can actually ensure that they are pulling in those data elements and that there as interoperable as possible. Just also wanted clarification as to what we are digesting as a work group so that A.) we are having the correct standards of SDOH that are included, B.) we are updating them on a frequent basis as we continue to evolve, but yet we are also making sure that they are as interoperable as possible. Not too specific but allowing for that specificity as needed.

Sarah DeSilvey

Thank you, Medell. Before Al leans in, I just want to state the base problem, which is that health literacy existed in Level 2. Gravity has addressed health literacy as a domain so, within the work of Gravity, there is evidence-based guided collations of instruments, diagnoses, goals, and interventions but neither the submission nor ISA reflect that at this time. The statement is trying to resolve that confusion, that there are standards to support this. Medell, I hear you. Al, do you want to lean in?

Al Taylor

Please. Thank you. First of all, I was not sure if the text that is in the second half of this cell has been changed because that is what I had a week and a half ago when I first put this draft letter together. If there were any recommended changes to that text…

Sarah DeSilvey

Everything has been changed as of this morning.

Al Taylor
Okay. We will transcribe those changes into the letter, obviously. I had a question. Maybe it would be good to clarify this. The word include, I am not sure what that means as far as a recommendation goes.

Sarah DeSilvey
The wording of it…again, I tried to synthesize Dayo's and Hans' and my conversations over the course. However, it needs to be addressed. I think the idea is if you look at the existing SDOH activity, SDOH domain submissions across the four activities, they were representative of domains of reference in that submission and they are no longer aligned with what exists. However, we need to support implementers in USCDI and ISA with understanding the domains that are included in guidance across USCDI and ISA is great. If include is the wrong word, happy to edit accordingly.

Al Taylor
I can imagine that include means call out as a specific example, for one. I did want to mention something to address Hans' question or statement about what is required of EHRs. We intentionally placed examples separate from the definition so that we would not convey the impression that every EHR must include these domains. It makes sense to include at least those three domains that we currently list because they are such a core part of SDOH care. Adding an example or several examples or referencing the Gravity work would not change the requirement For EHRs, only guiding them toward, "These are some things that might be useful to customers or may be required in certain care settings so that the EHRs would support care settings." Adding an example would only add attention to that example not add a requirement to EHRs.

Sarah DeSilvey
Thank you.

Steven Eichner
This is Steve. Just to add in thinking of the recommendation for annually updating. Just making sure we are consistent with the way USCDI elements are added through the ONC New Data Element and Class (ONDEC) process. How are new elements being inserted into that process if there is not an element included in a Level 2 or included in an ONDEC submission. It may not be appropriate to update it or we have changed the underlying process.

Sarah DeSilvey
Steve, I think we are getting a little…because you are talking about calling out specific elements, I believe, and we are speaking to representative example elements. I can assure you the process that we are speaking of here would include going directly through ONDEC. Not deviating from correct…

Steven Eichner
All right. I guess I was looking at the language and it plainly stated, "Recommend that ONC annually update the SDOH USCDI elements to include additional completed Gravity Project social risk domains." What I was calling into question with my question is that reading it plainly looked to me like the elements out of SDOH would be included for the additional risk domains. I was just trying to think about what that process looked like or how do they get included into on deck or as a Level 2 element for inclusion. I was not sure what the process would be for including it, if that makes sense.

Sarah DeSilvey
We can specify the process in the recommendation. Again, just for the sake of time…I know we have a lot to address in Level 2. Again, we can refine the wording, but I think what we did over the course of the last week was walk back on…our language was confusing because our language seemed to support a specific element for health literacy, which was not the outcome of the collaboration between Dayo and Hans and myself. It was more to call out that it is confusing because health literacy was available as a Level 2, but it has also been addressed and has support for implementation through Gravity, so wanting to clarify a path forward. Hans?

Hans Buitendijk
Thank you, Al andall for clarifying. That certainly helps because what I am hearing from that, which would align very nicely, is to say that the recommendation is centered around including as an example, where the example is a "such as" not an "includes" anymore. It is not meant to be that you have to support everything but that they are good examples and more clarified. You can look up in Gravity and other places as to what are the instruments specifically. I think along those lines that Al described it would be helpful because that does not require at all health IT that needs to be certified needs to support all domains that are enumerated in some fashion. That is **[inaudible - crosstalk] [00:24:19]**.

Sarah DeSilvey
Yes. It sounds like inserting the word example makes a lot of sense. Hans, I am going to call on you. If you could help edit that? I am trying to do multiple hats at once. Also, I think it solves the include element as well. The example comment addresses a few concerns. If we want to talk about how the process element to support Ike, I think that addresses Ike's concern. Medell, I hope you have clarity on the how? This is not to say that specific SDOH elements that are super, super critical across…when we think of at the CMS and HHS top five, like food insecurity, transportation insecurity, housing insecurity, utility insecurity, and then social isolation are the really critical ones. We see them across regulatory drivers. It is not to say that you cannot call out those specifically in future guidance, but for right now, given the need to clarify what exists in the ecosystem, this is thought as a good first step. Are we feeling good?

Hans Buitendijk
I will try to craft something **[inaudible - crosstalk] [00:25:27]**.

Sarah DeSilvey
Thank you. Medell, did my statement make sense? Did we resolve some of the complexity of my confusing language?

Medell Briggs-Malonson
We did. Again, we just need to make sure that the language is clear. I think, if we already have some of these various different standards that include things such as…and will continue to evolve throughout the additional upcoming versions. Having that clear language is going to be key. Yes, it does.

Sarah DeSilvey
Wonderful. I can attest that each of the ISA pages for the domains of reference include links to all aligned guidance for every single domain. Again, just implementers. On the ISA side, we got that covered. All right.

I think we can keep on going. I think, quickly, down to specimen collection date and time. I want to make sure that we touch upon at least all of Level 2. I think we actually addressed this one. If we go back to the final recommendation, I think we were at a clarity on the final recommendation. Is there any further comments there? Wonderful.

Again, I want to make sure we touch upon all of the Level 2 elements. We have had some conversation on the adding substance food as a specific nonmedication substance. We did substance on medication in prior IS WGs and prior USCDI versions. There was agreement that I heard on calling out specifically substance food; however, if we go to the final recommendation column, I do not see a final recommendation there yet. How are we feeling on the substance food because it would be in column M. Is it in the work group discussion? Oh, here we go. Shelly, in the comment you have here and would recommend including, is that a final recommendation or do we need to still craft that?

Shelly Spiro
This is Shelly. As I said before, that would be my recommendation because normally when we do allergy intolerance we break them into the three categories of medications, food, and environmental.

Sarah DeSilvey
We have…okay.

Shelly Spiro
It is good to do because many of the systems use those three designations as indicated.

Sarah DeSilvey
At present, I believe that only substance food is a Level 2? Right? This is the only one that is eligible for addition.

Shelly Spiro
Level 2. Yes.

Sarah DeSilvey
If it is simply an addition because of the conversation we had before, it would not require a final recommendation comment, right? If we all agree that it should be there, it is a Level 2, right? When it gets to Level 2, we might have to draft something. I am just trying to keep us going. Are we all in agreement that elevating substance food from Level 2 to USCDI is something we want to do? All right. Al, my apologies. I am trying to make sure I am doing the facilitation bit. Because it is a Level 2, we are going to have to draft a final recommendation because it is not USCDI v.5 bulk include, correct?

Al Taylor
Right.

Sarah DeSilvey
Right. I do need someone to take lead on drafting a final recommendation there. It can be very straightforward.

Shelly Spiro
I can do that. This is Shelly. I can do that.

Sarah DeSilvey
Thank you so much. Are we all in agreement that we should do that?

Steven Eichner
If you want help, this is Ike. I am happy to do some.

Sarah DeSilvey
Thank you.

Shelly Spiro
Ike, if you could just review what I put in, that would be great.

Steven Eichner
All right.

Seth Pazinski
We are doing this in real time, Sarah, right? It is going to be done right now and we are going to look at it. We are done. Okay. Thank you.

Sarah DeSilvey
Yes, sir. I want people to go in there and do that. I wish I was smart enough and had enough hands to do it myself. Al?

Al Taylor
As this recommendation is being drafted, I would include some additional information or discussion about why food should be separated out from nonmedication. Just as a suggestion.

Sarah DeSilvey
Yes. Thank you so much, Al. I believe that was part of the discussion we had last week because Shelly was calling out how they think about specific nonmedication allergies from a subtype perspective and this was the first step. I believe that can be contained in the recommendation. Thank you so much. All right. I think we are ready to move on. Again, if someone can ping me when we have… I think the recommendation is so straightforward, but if somebody could ping me when the recommendation is ready and we want to revisit it. The next element was family health history. Again, if we go over to the final recommendation, thank you for taking the lead on that. Because it is a Level 2 element we did need to draft recommendation. This is incredibly straightforward. Thank you for giving the example of how to do am incredibly succinct Level 2 recommendation, Mark Savage. Al, you still have your hand up. Do you have anything else you want to…

Al Taylor
Oh. I thought it automatically went down after I started making noises. Sorry.

Sarah DeSilvey
It is back up again. Yes. Any conversation on family health history as a Level 2 element elevated to USCDI v.5? I believe we touched upon it. Are we all in agreement that it should proceed?

Al Taylor
Another thing that I would suggest. If there are recommendations about a specific definition, examples, usage, notes, or applicable standards, which I do not believe there were any applicable standards. There might be. If there are specific recommendations about how the entire data element should be crafted that would be good to put in the recommendation as well.

Sarah DeSilvey
Thank you, Al. For the sake of ensuring…oh, Mark?

Mark Savage
I was going to volunteer to try to do that in real time. I am not sure about value sets but I will definitely be able to include the definition. I will do my best.

Sarah DeSilvey
Thank you, Mark. Again, my apologies to the person who is driving. We are going to be bopping up and down a little bit. Hans has let us know that my awkward language was revised in the health literacy element. If we can just quickly revisit that and make sure individuals are content with the clarification. I am sure it is better than what I had. If we go up.

Hans Buitendijk
It is in N19 next to it.

Sarah DeSilvey
Oh, N. Okay. If we can go over one column?

Hans Buitendijk
Yes. You can compare and contrast.

Sarah DeSilvey
Perfect. Are we just talking about assessments, Hans? It is through all four. All four of the SDOH elements contain health literacy guidance. The language of this looks beautiful. Are people in agreement? I think this is much clearer than what I wrote.

Hans Buitendijk
Do you prefer SDOH elements?

Sarah DeSilvey
That is fine. Yes. I think so. Do we agree that SDOH elements is sufficient to represent the four elements across the SDOH? Relevant? Great. For the sake of clarity we may want to spell it out the first time and then use the acronym later. I feel like this resolved. I believe this is clearer than what I wrote. Does everyone else agree? Great! Thank you. Content always improved by good editors. Thank you so much. If everyone

is agreed, perfect. Yes, teamwork makes the dream work. Now, we are going to revisit health insurance information. If we go to the final recommendation. Again, I do not see Aaron here. This is a fairly straightforward process because this is something IS WG has been covered in the past. Mark very kindly went back. This is the bonus of having legacy IS WG members who have been around to help us with what IS WGs have been said prior. Mark?

Mark Savage
I misspoke last call so I wanted to call out that this is not repeating a prior recommendation. This is a recommendation to add additional Level 2 data elements to an existing data class. Everything else, I think, is straightforward but I wanted to say that out loud, that it is additional not the same. Thank you.

Sarah DeSilvey
Fantastic. Now, do we have a discussion on this element? How do we feel about the addition of the remaining Level 2 elements in the health insurance information data class? Derek?

Derek De Young
Yes. I agree with the importance of it. My worry is more in the implementation and usability of it in the current state of the world, I will say, because what are we trying to drive with the plan identifier? Those will be very inconsistent across…even within a single EHR, health system to health system across, from Epic's perspective, even across different instances of Epic, if we are pulling that from health systems. Providers consistently make their own peer records and plan records to represent their contracts with the health plan. Those plan identifiers will be useless outside of that health system. I am curious what we are trying to drive with exchanging that. I can understand maybe product type, if that is what we are trying to get to from plan because from a health plan perspective, health plans will have thousands of health plans, sometimes from employer to employer, but potentially what we are trying to get to is product type.

Is this a health maintenance organization (HMO), preferred provider organization (PPO)? Is this Medicare Advantage? Is that what we are trying to get to? My worry is plan and plan identifier is not very useful information, especially if we are pulling it from a health systems understanding in record. If we are pulling from a health plan that is a different conversation. From a health system, I worry about this.

Sarah DeSilvey
Thank you. One of the things I want to highlight is that oftentimes when we hit things like this, when it comes to implementation and we are not quite ready for go live, we pull those two out. What I hear is there is little concern regarding coverage priority, policy number, Medicare payer identifier, payer name, and group name? But there is **[inaudible - crosstalk] [00:37:53]**…

Derek De Young
Even payer and group name. I do not think group name is consistently documented on the provider side. I know it can be sent in RTE, real-time eligibility, but the source of truth to that is the payer. It can be stored in the health system side but that is, I would not say, consistently…the group number would be stored more consistently than the group name. The payer name, again, if we are pulling it from the provider system, inconsistent across providers. For some of the national payers, it may be somewhat consistent if you are doing population health or some research things. You can say name includes Humana or name includes

United but the exact names will differ from provider to provider. Medicare patient identifier, I think is a good one for sure. That can be added. That is consistently documented.

Coverage period is also one where I do not know how accurate that will be. Sometimes when a provider is creating a coverage for the first time the start date will be the date that they documented that coverage and then they will not include an end date where maybe the coverage is actually valid for a year before that. It is not going to be necessarily accurate because it has not needed to be accurate except for billing purposes on the health system side. Just worried a little bit about some of those. Again, if we are pulling these from a health plan, these all make sense. If we are pulling these from the health system, the accuracy of these elements, I would not vouch for. The only reason some of these are collected is for billing purposes.

I am reading some of the chats. I wanted to bring up some of the concerns about the area. Again, I think they are important and can drive a lot of usability but there will be vast inconsistencies across health systems with these.

Mark Savage
Ike, can you jump in?

Hans Buitendijk
Did I drop, too?

Pooja Babbrah
We can just go ahead. Yes.

Hans Buitendijk
Did our moderators both…

Seth Pazinski
Go ahead, Hans.

Wendy Noboa
It looks like Pooja is technically next.

Pooja Babbrah
That is okay. Go ahead, Hans, and I will go after.

Hans Buitendijk
Sorry. I would like to echo some of Derek's comments but to primarily focus on the plan identifier because that is indeed one that is much more internally defined as part of Fast Healthcare Interoperability Resources (FHIR) in support of USCDI version four, which is going through its final steps. Not much will change. A number of these fields are already in there. That does not mean that it is going to mean everybody is going to consistently do. That is still the concerns that Derek raises. At five years, it is already starting to put them in as must supports as part of coverage. I think the ones to really look out for are plan identifier. That is a question of what does it mean. It is almost like a medical record number of a patient. It varies by whomever you are. It is not consistent across the board.

Is that one that we really can promote at this point in time? Other ones I think as part of the recommendation we should make clear that work is needed to help address consistency, to help address that it is from the source and not filled in differently by a provider otherwise. The other last one is the Medicare patient identifier (MPI). Depending on how we look at it, which is not necessarily a problem for USCDI, but it can already be covered in the identifier that is available to identify that it is a Medicare patient. I presume it is the same as Medicare beneficiary identifier (MBI)? I am always confused, because I hear MBI and I sometimes see MPI. I believe it is intended to be the same.

We do need to have a little bit more work that we consistently know that an identifier is actually a Medicare identifier by knowing who is the payer and otherwise. Caution to be had on consistency. Plan identifier, I am not convinced that that is currently a proper one to include. Other ones are already starting to be addressed.

Pooja Babbrah

I will just add to that. I think this was already said in the chat but I think this is really important to keep in. Let us limit it then to keep conversation going to may be the ones that Hans identified that are already part of before. That would be my suggestion as a compromise or a way to bring this forward. I do think this is important to include.

Medell Briggs-Malonson

Hello, everyone. I also think it is incredibly important. Sorry if I jumped in. I cannot see if there is a hand there. I also think this is incredibly important, but I definitely recognize what both Derek and Hans are referring to with the inconsistency of health plans. Hans, you mentioned the plan's ID. Does that also include the products within each health plan? Do we have specific identifiers for that because that may also go directly within our recommendation. What I mean by that is that let us say that we have Anthem but of course we know that Anthem also has various different sub products underneath Anthem, whether it is Medicare Advantage, Medi-Cal, all of those of an aspects. Do we have sub identifiers for each of the products also that the health plans have?

Hans Buitendijk

Currently, in FHIR's core, there is a coverage type and there has been some discussion around types. There are elements around that to be able to identify is it Medicare, Medicare Advantage, etcetera, etcetera. There are elements already addressed. The question is that if we do this we should have a look a little bit more about what is already there and what is missing from that, what is not able to address that, and make sure that when we say product type is that covered by, for example, coverage type and is it covered by payer class or coverage class, some of those elements that are in there that are currently going through final review and publication over the next month or two, I think. Three, maybe?

Medell Briggs-Malonson

Thank you.

Sarah DeSilvey

My apologies, I lost internet service and got bumped to Vermont. I am back. Are we still discussing the insurance elements? I assume so based on the conversation.

Hans Buitendijk
Yes.

Sarah DeSilvey
Hung, I can see that you have your hand up. Thank you for allowing me to reenter and continue with facilitation.

Hung Luu
My question was around how well does CMS prior authorization final rule impact the need for the health insurance data elements? I mean, 2026 is around the corner so I assume people have been thinking about how to work towards the requirements that final rule states. Have we thought about how to communicate the eligibility and the prior authorization requirements beyond the EA chart of origination? I mean, patients are portable and so they are moving around and the information around whether or not there is a prior authorization for a certain test or a procedure or medication is important to have. I see this as an important data element to help support that. Am I wrong? I mean, am I misunderstanding something?

Derek De Young
This is Derek. I will just hop in. I do not think you are misunderstanding at all. We have provided feedback with the CMS final rule as well, that one of the biggest needs in this space is a national payer directory so that there can be consistency in this. Otherwise, even with the CMS final rule, for 2027, there will be a lot of one to one implementations of providers and payers needing to map their internal payer and plan records to some endpoints that need to be loaded into their system to communicate these things. Also, just because we can exchange this information between health systems does not mean that health systems will necessarily stop communicating with health plans to verify coverage information using existing standards, like real-time eligibility, because those are Health Insurance Portability and Accountability Act (HIPAA) mandated transaction sets that exist today. They can help that process of potentially identifying…this may be a coverage that we can query for so that will be a helpful thing to add.

Sarah DeSilvey
I am going to ask for a census because I was again bumped out of the meeting for a period of time. I hear couple of different recommendations on the floor. One is adopting the recommendation as it stands. Another, to adopt it with edits and taking out elements that are not deemed ready for implementation at the time. Is that what I am hearing? Hans, you have your hand up. I see some people in the chat speaking to you regarding this. If someone can catch me up? Again, my apologies because I literally lost service for a little bit and I am back, Hans. Then we can move this one forward. It looks like recommendation in general for most of these concepts, some concerns with some of them. Hans?

Hans Buitendijk
I was actually just typing. As we were possibly going to the next topic. To Hung's question, CMS recommends the use of da Vinci guides. That includes coverage and when you look at those two, between the da Vinci guide and the FHIR US core, they are very close. I cannot say right now exactly the same but they are very close. I think maybe the phrasing of the recommendation can be enhanced with a little bit of work. Happy to work with Derek or others to see where we can clarify where we need to focus to make this better. We are obligated to still look at plan identifier to be concerned about but the other one is much more

about how can we make sure they are consistent and can be easily used to reach out for a prior auth for audit purposes as well. What is missing? I am not sure that means USCDI is missing anything but it is the implementation of them to make sure with everything else, as works as Derek indicates.

Sarah DeSilvey
Again, I hear go forward as it is. I hear go forward but remove plan identifier and then ensure that our recommendation includes the implementation complexity that Derek is speaking to. Because again, it does not have to be perfect in implementation for us to make the recommendation because the recommendation drives the alignment. Right? Am I understanding that correct? Are those the options we have on the table? All of the elements as they state and all of the elements except a plan identifier? Am I hearing correctly? Again, catching up.

Hans Buitendijk
Yes.

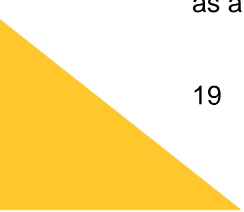
Medell Briggs-Malonson
Sarah, yes.

Sarah DeSilvey
Thank you so much. Can I just have a show of hands for leaving it as it is, the first one? Then, next, I am going to do taking out plan identifiers. Show of hands, who wants to have the recommendation as it stands right now with all of the elements on the list? I see two. Show of hands for those of the work group who want to remove plan identifier and otherwise include all of the others? Okay. That is a clear consensus on that one. I do hear there can be improvements in the guidance to represent…Again, Derek, thank you so much. We have a couple really thoughtful practical implementation considerations, and maybe we can work on the recommendation to include some of that perspective. Because that is what we do. IS WG adds expert advice from our different perspectives. Does that sound like a good plan for next steps? Hans, I heard you leaning into that.

Hans Buitendijk
[Inaudible] [00:51:55] whomever is **[inaudible - crosstalk]** happy to join as well.

Sarah DeSilvey
Okay. Thank you so much. Moving forward but taking out plan identifier and then a little tweaking to the final recommendation. Again, that is sufficient. I mean, if we have time to do it today that would be lovely. I do know that there is a lot to get done today, though. Thank you so much for leading that. I believe now we are ready to move onto the next element, which is the maternal social determinants of health note. I believe Christina and Mark were drafting the text recommendation for that one. It is a beautiful recommendation by the way. Christina, instead of the last 30 seconds of the IS WG, I am happy to hear your perspective on this element. Thank you so much. Oh, you are muted.

Christina Caraballo
Oh, sorry. Thank you. Mark, please chime in as well. It would be great if people take the time to review what is written. Mark and I spent the last couple of days chatting through email. Basically, this was identified as a major high priority with maternal mortality rates extremely high within this country, we are seeing a lot



of attention from the White House and priorities to address maternal mortality and it is extremely noteworthy that it impacts African American and Alaskan Native indigenous American women more with death rates. Really looking at health equity as well as. I see on the chat…could we move the recommendation to the left so people could read it on the screen? Thank you.

That was identified as a high priority, the reason we think that this should be brought up into diversion five. There is also a second recommendation, recognizing that we cannot put forth new data classes and that is not our charge. We did add a recommendation that ONC explore the presentation of data elements in USCDI specific to maternal health considering what a high priority this is. This could be in the form of a new data class, such as maternal and newborn health, and/or identifying a way to identify and mark the necessary data elements. This goes back to a couple of our discussions we have had throughout the course of this work group on how do we bring forth new data classes. Are they new data classes? Is there a way to identify? Recommendation here is just highlighting the importance of maternal health more broadly than just the maternal health social determinants of health note and tasking. Recommending that ONC take a closer look in their next iterations. Mark, did you have anything to add?

Mark Savage

No. Very important.

Sarah DeSilvey

Thank you so much. Hannah?

Hannah Galvin

Thank you. Is there any recommendation, or do we have any recommendation, about how this is used in the maternal record versus the infant record or both? There is a lot of thought or concern about how some of the maternal data then is incorporated into the infant record. That may be beyond the scope of what we are doing here, but where we have a lot of this information, which is extremely important information to the maternal record. I think it begs the question a little bit about how this would be incorporated in the shared record with the infant. I do not know if we want to speak to that at all or at least make recommendations that that might be looked into in relation to this data element.

Christina Caraballo

Mark, I know you had brought up in our discussion some of the stage zero data elements around this. Did you have a comment on Hannah's question?

Mark Savage

Sorry, I was focusing on family health history when Hannah said what was very important. I apologize. Hannah, could you please just say it again? Forgive me.

Hannah Galvin

Yes. Absolutely. My question was if we had any recommendations on how this data element would be incorporated in the shared record with the infant record as well because a lot of it is relevant to the infant's record and yet there are some privacy considerations, sensitive data considerations. That may be beyond the scope but also important as we consider these additional data elements as well.

Mark Savage

The question is important and entirely valid. In the short time Christina and I had, we did not see a way within our scope to try to pull the different data classes together and thought it actually would benefit from having ONC look at this, hence Recommendation 13, and consider how best to synthesize those things. That is why you have a more general recommendation on 13 without getting into the details.

Hannah Galvin

I will leave it there. Yes.

Sarah DeSilvey

Thank you. Medell?

Medell Briggs-Malonson

Very quick comment again. I completely thank the two of you for putting this together and completely support it as one of the individuals who was helping to lead to address maternal morbidity and mortality across the entire University of California health system, and especially by using our data. This would be incredibly helpful for us to address this horrible epidemic that has been plaguing our country for decades. I think the general recommendations are spot on because there is a lot of work that we still need to do in this space. Also, thinking about specifically maternal mortality actually exists even up to 42 days after delivery. That is how we also define it. Gathering those specific maternal social drivers of health are going to be incredibly important for us to prevent mortality morbidity. Thank you and I completely support this in every way.

Sarah DeSilvey

Thank you so much. Ike?

Steven Eichner

Minor word edit in the second line of the US Maternal piece, looking at maternal social determinants of health. Note those existing clinical notes do not. It supports collection of the most critical elements is suggested text. Also, I think there is an opportunity to link or connect the element here with USCDI+ and some recommendations about ensuring that USCDI+ includes additional information about maternal and child health issues. Another opportunity to link the two together because it is a crosscutting issue not just from a USCDI perspective but also from a USCDI+ perspective as public health interests.

Sarah DeSilvey

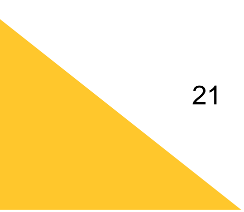
Thank you so much.

Christina Caraballo

We can add to 13 that we recommend ONC also explore adding this to USCDI+ as part of their process in the current recommendation, the text change.

Steven Eichner

Yes, those are minor edits just to clarify that the new element added or new class added does not require collection but it supports collection of it because it is the note. It is not distinct data elements.



Sarah DeSilvey
Fantastic. We are a little bit behind in our schedule and we had a lot to address today. Rochelle?

Rochelle Prosser
Very quickly. Thank you so much. In changing the recommendation in the word so that we can incorporate the infant into the data collection because where the mother goes so does the infant. Both are in consideration when we care for both. Can we add the word infant under the title or within the quotes of maternal social determinants of health notice to update it to maternal and infant social determinants of health notice? I think that will at least begin the discussion and the consideration in having that unification or separate data collection that is collaborative for both the infant and the mother.

Steven Eichner
Or at least linked to collection.

Rochelle Prosser
Yes, at least linked. Just to begin that process. I know it will take a hot minute to get it going but if we can at least start that thought process.

Christina Caraballo
I heard a separate recommendation in there. Sarah, if we are going to recommend a name change to the note should we vote on that? I see Mark has his hand up.

Sarah DeSilvey
Mark, do you want to help?

Mark Savage
I wanted to check. This is a part of what Christina and I were talking about. The note is a focus note and does not cover everything, hence the recommendation for data class. I am not sure the note includes all that we would want around infants even though that is obviously critical. What I have not checked out yet is whether we are then changing a Level 2 data element. If you want to defer, I could try to look quickly. I do not know as we are talking right now.

Sarah DeSilvey
Yes. That might be, Ike, in the realm of additional submissions for future consideration. I think it was Rochelle was saying that? I want to make sure we do not deviate too far from the initial recommendation in Level 2.

Steven Eichner
The other approach.this is Ike real fast…would be to include a suggestion as part of Recommendation 13 to include exploration of expansion into infants. Just more of a general recommendation approach.

Sarah DeSilvey
That makes sense. That is in the recommendation of guidance as opposed to direct referencing. Hans?

Hans Buitendijk

Two questions. One, is the intent of Recommendation 12 that it becomes another clinical note type? If I hear correctly a narrative note. Is that where it is a different type as we have talked about emergency, operating procedure, etcetera, etcetera. Is that where it belongs and/or how does it relate to earlier discussion on overall social determinants on health? Is this not a domain space that is also across all four elements but now in a particular context of maternal and infant? I am trying to get a little clarification on how it relates, where it would go, where it would fit in those two areas.

Sarah DeSilvey
Mark, you have your hand raised. You also put the comment in the chat. It is distinct insofar that it is a clinical note as opposed to one of the existing SDOH elements. It would leverage similar data, though. Correct, Mark?

Mark Savage
Yes, my hand was raised to go back to the point about infants.

Sarah DeSilvey
Okay. Hans, I hope I answered your question. It is in the notes class and that is not a place that the existing SDOH elements exist. Mark, do you want to go back to infants?

Mark Savage
Yes. I think the language of the note that is on the Level 2 website is broad enough to, especially because infant or just before prenatal care is definitely a part of maternal care. It is probably broad enough to include a word like that in our recommendation without exceeding what is stated in Level 2. That would be my opinion.

Sarah DeSilvey
Could someone summarize the findings for this…I hear general approval for elevating the Level 2 element to USCDI v.5 given the critical nature of the concern. I hear comments on wording in the text of the core recommendation, Recommendation 12. I hear comments on suggested next steps in the general recommendation in column 13, including but not limited to the exploration of infant elements in the class. Is that fair?

Hans Buitendijk
One suggestion that is in the main line of the recommendation, recommend that ONC add, that it is clearly indicated in there that it is added to clinical notes and then the explanation for it highlights that as well. Otherwise, it gets lost. At least, I **[inaudible - crosstalk] [01:05:59]**…

Sarah DeSilvey
Fantastic. That makes a lot of sense. Everyone agree? I will do that right now. I want to thank Mark and Christina for doing a lot of heavy lifting on this. Rochelle, we use…that is a good discussion on determinants and drivers. CMS is not even clear on this.

Rochelle Prosser

It is not me. I am just going to acknowledge Medell. Medell is the one that was talking about it. Since my adding in the word infant caused that discussion I wanted to also edify what she is saying and say will this actually change the Level 2 status of the question if we change determinants to drivers or social needs?

Sarah DeSilvey

I do recommend we keep our wording consistent, though. If we are using determinants in one area of USCDI I think we should probably keep it consistent in others. Am I…

Medell Briggs-Malonson

Sarah, I can jump in there. Thank you, Rochelle. I do not think we need to change it for this piece, but in general I think ONC knows how I feel about the term drivers as well as many of our additional federal agencies have moved away from the term determinant because it is so fatalistic and seems so fixed. Even CMS has moved away from the term determinant. I was just providing a general recommendation, especially for we, as not only this work group, but for overall HITAC, to continue to encourage ONC to no longer adopt the term determinant and for us to update our language to drivers and/or social needs. That is more reflective of how dynamic all of these elements are and that they are not fixed in their current states and present. That is all, just one of those general recommendations. Thank you all.

Sarah DeSilvey

Yes. Unfortunately, we did a landscape analysis. Hopefully, we will get to a point of clarity. Even if you look at IQR versus emerging measures, there are a lot of discrepancies in how it is named. Gravity is ready to lean in and support whatever is finally landed upon but the ecosystem is still in flux there. All right. Again, happy to have any updates to elements align with whatever the ecosystem finally lands on. Are we okay with this recommendation at this time? Are we good? All right. I believe you updated family health history? Mark, do you want to revisit that really quick?

Mark Savage

Yes. If you want to go back up to Al's question, I quickly went in and used language that is from the certification criterion. I am not making this up. The definition is there, the usage note is also from the certification criterion language. The standards are also from there. It provides some granularity to the basic recommendation as Al had requested.

Sarah DeSilvey

Thank you. Are we agreed on the revision of the element here? It looks good to me. Thank you so much, Mark. I think that we are getting close. I know I am pulling us past our agenda to try to get all these Level 2 elements set. I am not going to put you on the spot, Joel, if you are still on. There are a fair bit of things at CMS if he is. Yes, Joel is still on. All right. Shelly, you wrote a really beautiful recommendation on portable medical order, which is lovely. This is partly contained in the work we did on advanced healthcare directive information and it partly was aligned with Maria Moen's presentation. How are we feeling on the recommendation as it stands?

Shelly Spiro

This was not work that I just did. This was also with Mark and Hans.

Sarah DeSilvey

Fantastic. Thank you so much. Any concerns with the recommendation as it stands? Lovely. Then, Pooja, I hope it is okay to revisit now. If we are ready to move on, I want to touch base on the medication elements and some confusion regarding that. I believe we are going to circle around and then come back to the meeting with resolution, correct? If you look at the…

Pooja Babbrah

Yes. I think there was just one that there was confusion. Now, I think since Al is on, administration because we already have it as a Level I data element. I do not know if we can move the spreadsheet.

Sarah DeSilvey

It is right above…

Pooja Babbrah

Am I just not seeing it?

Sarah DeSilvey

Yes, it is the next element right above…if you go to the left. This element medication administration, I believe, was the question because we already had it. Was that the thought?

Pooja Babbrah

Yeah. Shelly, I see you have your hand up.

Sarah DeSilvey

You yourself were confused why it was here.

Shelly Spiro

If you look at Level 2, it is medication administration route. That is what was confusing us. We thought it was just medication administration, but it is supposed to be medication administration route and we needed a clarification from Al.

Sarah DeSilvey

Al, can you help weigh in on this one?

Al Taylor

Is the question about this data element as entered?

Sarah DeSilvey

Yes.

Al Taylor

I mean, I am not the one who entered it but medication administration is…if Pooja's intent was to advance medication administration route, that is something that is already being proposed.

Shelly Spiro

Right. That is why I think I was confused. I think we are okay just removing this one. Yes. Because route is already in unless it **[inaudible - crosstalk] [01:13:00]**…

Al Taylor

Well, yes. It is in draft. Yes. This question has come up by others, including and especially CMS, I believe, who had requested and recommended addition of medication administration as a separate event from other kinds of medication activities. Hopefully, I said that right. I do not think it was intended to be…were you the one that entered it, Pooja?

Pooja Babbrah

No. I was not. I know it had my name by it but I was not.

Al Taylor

I think it was recommended by….oh, yes. I see. It has in the past been recommended by CMS. Whether…

Sarah DeSilvey

There is some commentary below. Joel is on the call. In Row 29 of the spreadsheet currently there is medication recommendation, medication prescribed code. Joel, you are on the call. I am sorry. You asked for CMS and Joel is right there. Joel, can you help us here? I am sorry to skip you.

Joel Andress

Yes, yes. I see how it is. I will try to do my best. Right. The distinction here is that we want to see this as a distinct action within the medication process. Yes, you have dose and route. The data elements are recommended separately. The actual administration of the medication. Not that it has been prescribed. Not that it has been ordered but that it has actually been administered is a point. Not just for, I should say, CMS, but also for CDC in terms of being able to track information related to dose response, quality of care, public health response. The actual administration of the medication is frankly something that we see as a thing that is a gap in addressing medication data and one that requires us to engage in a number of workarounds for how we use medication data currently because frequently we have to use proxy data elements.

Yes, it was prescribed. Does that mean that it was actually taken? No, not necessarily. Of course, this enters some weakness into our utilization of the data elements. Administration, basically falls down to the point of entry for getting medication to the patient. We know the patient has actually received the medication and taken it. For the purpose of improving the specificity of quality measurements, for better enabling us to monitor response patterns to public health events, we are pushing for this to be its own independent and distinct data element.

Sarah DeSilvey

Thank you, Joel. There were a set of CMS requested Level 2 elements that happened right at the wire of our Level 2 elements submission. My apologies for not getting to them prior. Did this help clarify, Shelly and Pooja, the question?

Shelly Spiro

No.

Sarah DeSilvey
Okay.

Shelly Spiro
This is Shelly. Maybe I can elaborate on why I say no. Are you talking about medication administration status? That would make more sense. What we are doing moving forward when we have a project going on, to codify the medication FHIR resources, which would include all of the data elements and medication. To create what we call a medication list type. All of the medications that would fall into medication administration, like a record, like Electronic Medication Administration Record (eMAR), you would then be able to classify all of those medications using the medication FHIR resource and put it in the bucket out of the medication administration type, which would then show that it was administered. That is what I would believe…unless you want to change it to medication administration status? Was it administered or was it not administered? That would make more sense to me. Just having medication administration does not tell me what you are trying to record as a data element.

Sarah DeSilvey
Can I ask a question? I believe, actually, in last year's IS WG there was so many significant concerns regarding medications that came up that we wanted to have CMS, and the federal government, and ONC, huddle on a what needs to be built out into USCDI. We had the pharmacy work group, right? I wonder if we just need to make sure that we specifically lean into that for us, for considerations for next year, or do we feel ready? Al, is it to capture the process of procedure of giving medication? Yes, that is the intent.

Al Taylor
I asked an either/or question. I was not sure. Can we just clarify what…

Sarah DeSilvey
Joel, is it intending to capture the status of administered or is it intending to capture the process of giving a medication? Joel, do you know?

Joel Andress
My understanding is that it is intended to capture the status of it having been administered. That is what I am responding to. I apologize. I did not see the or statement coming after that.

Sarah DeSilvey
Okay.

Pooja Babbrah
That sounds like what Shelly was describing, then.

Sarah DeSilvey
Fantastic. Hans?

Hans Buitendijk
Thank you. A couple thoughts and comments here. Medication administration has been very confusing because if you look at the current definition of procedure and the data elements in it, it might be implied,

and I have confusion around, the fact that the medication administration date and time is given as an example of procedure performance date and time. Does that mean that USCDI implies that an actual medication administration record is implied in that? So far, we have heard no, that is not really the intent.

I think it points to the larger question for USCDI, that there are in lab, there are in medication, there is for imaging, there are different phases. What is the order? What is the schedule? What is the performance? You have different documentation requirements around these. Those are a little bit muddled within the USCDI at this point in time. If we talk about medication administration route, is it the route that has been requested to be used or one of the options that can be used or is it meant to be the actual route used at the time of the medication administration? I would strongly urge that we make a distinction in those areas explicitly in USCDI. Otherwise, we keep on going back and forth on these discussions. What is it? Recognize that there are workflow stages and performance stages that you go through and that we call it out and say, "We are currently interested in the request part, the order part, or we are currently interested in the administration part of it."

It all comes together that they have common data around medication, or around lab, or around imaging. There are different aspects that you need to highlight, different data that is relevant in that context. That is how systems currently work. That is how they communicate. That is how they interact with Version II, or NCPDP. We need to recognize that. Otherwise, we will constantly go back and forth on this conversation. What do we really mean? There is a valid perspective that we need to have medication administration. We need to have a lab result, as we need to have a lab order.

Some of the other discussions that we are talking about, to recognize, is that there is ordering the information that is consistent across all orders. It does not matter what you do. There is unique information to the medication versus a lab, versus an image, etcetera. How do we recognize it? Otherwise, USCDI is a very ambiguous tool that, once we get to FHIR US core, Consolidated Clinical Document Architecture (CCDA), and whatever, we have to tease that out and come to a conclusion on what was the intent. We put at that point in time what it is but we maintain a disconnect between what USCDI seems to imply and what we actually are doing. From that perspective, I really urge that we are going to be explicit about it and recognize those phases so that then we use medication administration in a way that I understand whether Joel is asking for a status, or the date and time, or whatever it is. At this point in time, I am getting lost between what aspects are we truly talking about.

Sarah DeSilvey

We have a few minutes before we actually have to go to public comment, very shortly. I feel like we all recognize that these are important. I feel like we need to make sure that the recommendation is clear enough to help us understand how to implement. I am trying to hold space for the fact that we are due to give our transmittal letter to HITAC and we have not yet delved into the complexity of these. Rochelle, any final thoughts on this? Anyone have any final thoughts on…

Rochelle Prosser

Yes. Looking at Steve's comment, and he brings up a very valid point, which is part of what I was saying within the nursing process. A lot of these data elements that you are trying to capture, is it a validation that the patient actually took the medication. What is the ultimate intent and goal as we go through these data element captures. A lot of this information is captured and contained within the clinical nursing

documentation sphere. Is that included as part of the process of where we point to look to incorporate this information? If it is, I think it is one of the very first things I brought up as we began this process of including the nursing notes as part of that data capture element and is this already addressed elsewhere?

Sarah DeSilvey
We have to go to public comment. I believe it does seem like we are landing on needing the April 9th meeting. Mark, can you help me understand what you were mentioning there?

Mark Savage
Yes. As you said, Sarah, we do not really have even the basic details of a recommendation. If we can, we would be on the 9th and add just a little piece. The basic letter would go, so they have most of it, but we would add a little bit something. I do not know if that is possible. That is why I wrote if possible. I do not know if there are some timeline requirements that make that doable or not.

Sarah DeSilvey
Let us do public comment and then maybe Al can help us with the process because we might have some time at the end.

Al Taylor
Public comment first or my response first?

Sarah DeSilvey
Let us do public comment first and then we cycle through.

Public Comment (01:25:28)

Seth Pazinski
All right. Accel, can you please open for public comment? If you are on the Zoom and would like to make a comment, please use the raise hand function. That is located on the Zoom toolbar at the bottom of your screen. If you are only on the phone, then you can press star-nine to raise your hand. Once called upon, you can press star-six to mute and unmute your line. We will give folks 30 seconds here to tee up. Okay, I am not seeing any hands raised. Accel, do we have anyone on the line?

Accel
No comments.

Seth Pazinski
All right. Thank you. Sarah, back to you.

Sarah DeSilvey
Actually, back to Al. Just to level set, we have a good set of content for an initial transmittal letter based on the extensive work that you all have done and we are incredibly grateful. There are the general recommendations and general process elements to discuss that I promised Hans we would get to but we cannot get to them. We also need to figure out what to do with the elements that are at the bottom of the worksheet that we have yet to address. Al, can you help walk us through possible process, like send the

transmittal letter and then reconvene on the 9th. We work at the discretion of ONC so we need to have assistance in figuring out what the next steps would be.

Al Taylor

It might not be advisable to send the HITAC co-chairs two versions of a letter because presumably they would have to review both of them entirely, even if one only has one edit. The alternative would be to deliver it very late, which is a possibility. It is just, we obviously try and get the public materials out three days or so before the scheduled meeting. That would be a possibility and we can certainly have the letter written all but these last recommendations. Finalize it on the 9th at the meeting, send it later on the 9th in a final copy. It might require some additional co-chair work later in the day, possibly, just because the finalized letter is going to take some time to put together.

Sarah DeSilvey

Can I ask a question? Unfortunately, the elements at the bottom…we got clarification on the one that was originally the top, on Level 2 medication administration. Would the work group be content with sending it as it is and then holding elements that were not addressed to next year? Is the discretion that our core charge was complete? Which is the USCDI v.5. We have not addressed everything in the Level 2 suggestions. We could call it sufficient but we have not addressed Hans' general recommendations comments. Hans?

Hans Buitendijk

Yes. I just wanted to make a comment about that. Actually, medication administration is a good example of what we are seeing that we made some comments about last year and it continues to have a need for addressing it to make USCDI more or less ambiguous and more in line with the standards that flow a year later. I think there is still an important part of the general process to have a look at. If they can still be discussed last week and then added, they are very much a continuation of the recommendations that HITAC has been made before. It would be a challenge in some ways that they would drop out this year on helping to make USCDI more useful than what it is.

Sarah DeSilvey

Understood. Steven, your comment. I know we are over time here. I do not know if Ike has a suggestion, but please have a show of hands for those of us who want to reconvene on the 9th?

Steven Eichner

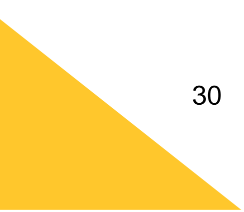
Before we do that, let me pose my suggestion. Do we have enough text together that the co-chairs can work with Al to put together a draft letter in the next couple of days and circulate that via email for circulation and decision-making via email say Thursday or Friday and then get it in electronically that way? Do we have a bunch that we actually still need to discuss?

Sarah DeSilvey

We have a lot we have agreed on that is the core part of the letter. We just had not discussed a few things. Seth?

Seth Pazinski

I just wanted to provide clarify. From a process standpoint we would not want to be working offline without having the opportunity to bring things back to the work group next week.



Al Taylor
Including public comment on it.

Sarah DeSilvey
Yes. Now, I am going to go back. We have two options. We have to work in correct formats. I apologize for being over time here. First option is to say we did not fully address Level 2 elements but we are submitting the final letter as it stands right now. We will move discussion on things we did not address to next year. We are going to have a show of hands on that one. The second is to come back on the 9th, complete the public process, and do a late transmittal. All understanding of the labor of co-chair is noted as I am in both spaces. Acknowledging my labor.

Option number one, show of hands, please? Submit as it stands. Option number two, come back on the 9th and revisit. I do not see all members voting but it is clearly… I see a clear consensus for the 9th version. I am going to close us out with a directive. There is not sufficient information in the Level 2 elements…the charge was last time that if there was a Level 2 element that we wanted to have, that it had to have a robust recommendation in the column to proceed. The Level 2 elements we were just discussing do not have that so that is the charge before we come back next week. There needs to be sufficient, clear recommendations so that we come back just to touch base on those. If I can be clear about that directive that would be great. Ike?

Steven Eichner
Agreed.

Sarah DeSilvey
Okay. Thank you so much. Again, we will see you next week and maybe will not have to have the whole meeting. Hans, we promise to start with the process things first. Thank you so much.

Adjourn (01:33:44)

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

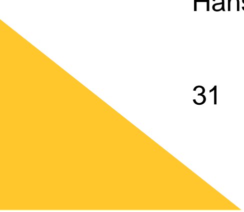
QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT
Katrina Miller Parrish: We remember it!

Shila Blend: Sorry im late, just to record Im present.

Hans Buitendijk: If examples can be added as "such as" rather than "included but not limited to", would help and clarify for awareness so when somebody is looking for relevant tools they are guided in a common direction, but not required to support all as they may not be most appropriate for the user community being supported.

Rochelle Prosser: yes

Hans Buitendijk: For SDOH Health Literacy have a look at cell N19



Sarah DeSilvey: ok!

Katrina Miller Parrish: Yes!

Rochelle Prosser: Yes

Katrina Miller Parrish: Team work!

Mark Savage: Inconsistency is not a reason to drop. Adding promotes consistency.

Pooja Babbrah: Agree mark

Hung S. Luu: How will the CMS Prior Authorization Final Rule impact the need for the health insurance information data elements?

Pooja Babbrah: Also - I'm assuming what comes back from eligibility check is what is stored in EHR?

Pooja Babbrah: I suggest we move this forward but remove the elements that are not in FHIR V4. Hans - I think you named the ones that are already in this version

Katrina Miller Parrish: Agree to use those in FHIR v4

Rochelle Prosser: Pooja +1

Hans Buitendijk: CMS final rule recommends use of Da Vinci CRD/DTR/PAS, which includes coverage data that include this data and syncs closely to FHIR US Core. However, the consistency and content challenges to enable getting to the correct endpoint needs work as Derek indicates.

Rochelle Prosser: Can you move over to the right so the recommendation is showing?

Rochelle Prosser: Suggestion to update recommendation 12 to change to " Maternal and Infant Social Determinants of Health Notice"

Mark Savage: Is USCDI+ in our scope?

Medell K. Briggs-Malonson: in general, we need a recommendation to ONC to move away from the term determinants and adopt either drivers or social needs.

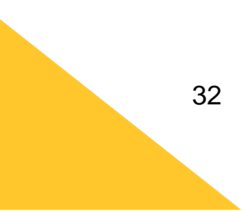
Mark Savage: Is in clinical notes data class

Rochelle Prosser: It was me that raised infants.

Hans Buitendijk: suggest to add to the main recommendation "...to Clinical Notes".

Mark Savage: Have made changes to Family Health History.

Rochelle Prosser: Mel can we change the wording of Determinants to drivers and still keep the LVL 2 without change?



Shelly Spiro: @Sarah added M21 final recommendation for adding level 2 data element food to allergy and intolerance data class

Rochelle Prosser: I hear you Medell

Katrina Miller Parrish: Agree Medell!!! Would love to continue to change Determinants to something else!

Mark Savage: +100 Medell

Rochelle Prosser: 100%

Hannah K. Galvin: Agree with Medell re: term "drivers." I notice that ONC used the use "determinants" in the recent 2024-30 Federal Health IT Strategic Plan as well.

Rochelle Prosser: minor dissent for the word determinants :)

Rochelle Prosser: Can you clarify the CMS position please?

Mark Savage: This happens because proposing to elevate to a Level 2 element to v5 leaves it showing in both places, Level 2 and draft v5.

Mark Savage: *elevate a Level 2 element

Albert Taylor: Joel, is this element intending to capture a status of "administered"?

Rochelle Prosser: SO can we pull this data from the Nursing note where the med administration occurs? Is that CLinical Nursing not not included as part of a classification in another element? Or can this be added here

Albert Taylor: or to capture the process/procedure of giving medication?

Rochelle Prosser: Or are we validating a medication consumption by patient.

Rochelle Prosser: Again all these clarification questions stem from the Nursing administration process.

Albert Taylor: https://www.healthit.gov/isa/taxonomy/term/3361/level-2

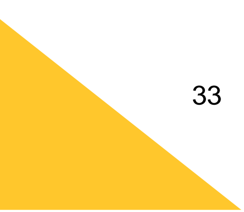
Sarah DeSilvey: note, we only have a few more minutes before public comment.

Pooja Babbrah: I agree with Sarah on making the recommendation to continue to look at this element through a pharmacy focused task group if we think those will continue

Albert Taylor: Medication Administration Status Level 2 element https://www.healthit.gov/isa/taxonomy/term/3361/level-2

Shelly Spiro: @Hans agree about medication administration

Steven Lane: The route on an order is indeed different than the route of actual administration.



Rochelle Prosser: Steven +1

Pooja Babbrah: +1 Steven

Steven Lane: We really should have both, as well as the route included in a prescription sent to a pharmacy.

Mark Savage: Either have meeting on April 9 to fine tune one piece of transmittal letter (if possible) OR not ready with final recommendation.

Steven Lane: Administration route could be captured by nursing staff as well as by a patient or caregiver.

Hans Buitendijk: Plus we have some additional general comments.

Rochelle Prosser: Exactly Steven

Rochelle Prosser: Agreed +Pooja

Hans Buitendijk: At some point we need to address the actual administration (what was actually given by a clinician and possibly what was taken by the patient at home). But we should do so explicitly, not implied by having to stitch multiple data classes with select data from each to get to that as we would not collectively agree on which data elements from what data classes to do so.

Pooja Babbrah: Agreed, Hans

Rochelle Prosser: COncur Hans

Mark Savage: Sounds like get one letter out now for the good of the whole.

Pooja Babbrah: I'm ok with holding the level 2 medication data elements

Mark Savage: Can live with that.

Steven Lane: It would be a shame to miss the opportunity to address the second component of our charge.

Steven Lane: I'd rather meet and include any recs we can agree on.

Mark Savage: Important to set up a smooth HITAC meeting with timely letter.

Katrina Miller Parrish: Need background info teed up for the 9th, please.

Rochelle Prosser: Thank - you Sarah

Katrina Miller Parrish: Thanks!

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

RESOURCES

IS WG Webpage
IS WG - April 2, 2024, Meeting Webpage

Transcript reviewed and approved by Wendy Noboa, HITAC DFO, on 4/12/2024.