Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

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

March 30, 2021, 10:30 a.m. – 11:30 a.m. ET

VIRTUAL

Speakers

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

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

Operator
All lines are now bridged.

Michael Berry
Great. Thank you and welcome, everybody, to the USCDI Task Force. I appreciate you joining us today. My name is Mike Berry. I'm with ONC and we have a fast-moving meeting today so I'm going to open it up quickly with roll call. I'll start with our cochairs, Steven Lane.

Steven Lane
Present.

Michael Berry
Leslie Kelly Hall.

Leslie Kelly Hall
I'm here. Good morning.

Michael Berry
Ricky Bloomfield. Hans Buitendijk. Grace Cordovano.

Grace Cordovano
Good morning.

Michael Berry
Jim Jirjis. Ken Kawamoto.

Ken Kawamoto
Good morning.

Michael Berry
John Kilbourne.

John Kilbourne
Good morning.

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

Mark Savage
Good morning.

Michael Berry
Michelle Schreiber.

Michelle Schreiber

Good morning.

Michael Berry
Sasha TerMaat.

Sasha TerMaat
Good morning.

Michael Berry
Andy Truscott. Sheryl Turney.

Sheryl Turney
Good morning.

Michael Berry
Daniel Vreeman.

Daniel Vreeman
Good morning.

Michael Berry
Denise Webb.

Denise Webb
Good morning.

Michael Berry
Okay. Good morning, everybody. Thank you and I will now turn it over to our cochairs, Steven and Leslie.

Tasks 1b and 1c (00:01:32)

Steven Lane
Thank you so much, Mike. Just for the record, I see both Clem and Ricky have joined so we'll count them down. Thank you all for joining us today. We do have a shortened meeting because of the ONC meeting which starts in I think an hour and a half. The only team meeting yesterday was with Excellence. I hope many of you have time to attend today. It's a really great cast of characters that are presenting there. We wanted to take advantage of this additional hour, knowing that we have only a little time left to prepare our recommendations to the HITAC, which are going to be due I think on the 15th of April, if I recall. We've got a few weeks to go. Again, we're focusing on the Task 1C at this point. Just to be clear, past meeting notes continue to be posted as they are finalized to the website so people can have the opportunity to look at those as you see fit and raise any concerns that you have. I think we are largely done with Task 1B at this point and have collected everybody's input on that. If new items come up, you're certainly welcome to bring them to our attention. Again, with Task 1C, you will recall last time there were a number of items that we were going to come back to revisit. Is Al with us? Al, you are. I see you.

Al Taylor
I am, yes.

Steven Lane
If you wanted to bring up the USCDI Task Force Member Recommendations spreadsheet in whatever level of Zoom you think is most appropriate, I invite people to be looking at that yourself in real time so that you can see just what you want. Then Al will also have that up. We want to complete Task Force recommendations. We've had a number of discussions on 1C items and want to try to complete our recommendations. I want to turn it over to Michelle's Schreiber, who was discussing a number of recommendations from CMS that we had some questions on. Michelle, if you can kind of give us an overview on what your team is suggesting and drive us through the 1C items for which you seek our support.

Michelle Schreiber
Thank you. First, I want to express to the entire committee on behalf of CMS our thanks for listening to these recommendations. I had a number of meetings during the week with others as well. I want to clarify a few things and I hopefully can find them on the table. I do want to close out our recommendations on the problem list because there was a lot of discussion about that, whether or not to include ICD-10 along with SNOMED for problem list. We had a conversation with the VA recently and we recognize that there are people who would prefer just SNOMED, not adding ICD-10. However, CMS still believes that because of the ubiquity of coding and information that occurs in ICD-10, we would like to continue to support having both. Not that you have to have both in the same field, so it's more like either but adding ICD-10. I think the VA agrees. I don't know if John Kilbourne is on and wanted to say that and wanted to provide their opinion. I wanted to clarify that is a conversation that we have had with them. Is John on, do you know?

John Kilbourne
Yeah. I can corroborate that statement, Michelle. Yes. We discussed that yesterday. We think in the interest of the greater good and future data elements, that would be more SNOMED specific for quality measures in the hope of working closely with CMS. We are going along with this.

Michelle Schreiber
Thank you. I am sorry.

Steven Lane
Michelle, just to be clear, we've got a couple of different issues but you're speaking specifically about problem list diagnoses, correct?

Michelle Schreiber
Problem list diagnoses, that is correct.

Steven Lane
Okay. I'm trying to find it on our list.

Michelle Schreiber
Yeah. I **[inaudible] [00:06:11]** table. I'm sorry I couldn't.

Steven Lane
Okay. We'll find it. We'll find it. Before we leave that item, the recommendation then is that for problem list diagnoses that the suggestion is that either ICD-10 and/or SNOMED would be acceptable coding for that data when it is transmitted. Does anybody have any objection to that recommendation? All right. I mean, it

makes perfect sense to me personally. I do appreciate that. I'm still trying to figure out what row it's on, but we will find it.

Mark Savage
Steven, it might be row 43.

Michelle Schreiber
I'm sorry. We're looking in the editable one. Is that right?

Steven Lane
Yeah. There we go.

Mark Savage
I see it on row 43.

Steven Lane
Thank you. Thank you so much, Mark. I appreciate your help.

Mark Savage
Yep.

Steven Lane
We currently suggest that ICD-10 be allowable for coding a problem list diagnoses. It says consider requiring ICD-10 while continuing to allow or require the use of SNOMED. It sounds like at this point we're simply saying either or both, if I'm not incorrect, would be acceptable. Does anyone have a different understanding? Good. All right. I will change that up and we will consider that final. Okay, Michelle, where do you want to go from there?

Al Taylor
Sorry. Just to go back to this, by adding ICD-10 as an applicable standard, that would require ICD-10 as well. I just wanted to be clear on what it means to add. That's fine to have that recommendation but any code is allowable but only one code currently is tested, and that's SNOMED. The implications of adding ICD-10 as an applicable standard would be that it is now required.

Steven Lane
Okay, that is interesting.

Michelle Schreiber
Al, that would be required for availability, but not required for use. It would be either one for use, just to be clear?

Al Taylor
Yeah. Adding it to USCDI just adds to the requirement for certification.

Michelle Schreiber
Okay. Thank you.

Steven Lane
We would add it as an allowable standard for problem list diagnoses. It would have to be tested and supported but it would not – In a given transmission, would it still be acceptable to send only SNOMED?

Al Taylor
Sure. That would always be –

Steven Lane
Okay.

Al Taylor
The content, yeah, it would still be acceptable to send. Well, it would be acceptable to send either one because both would be required of the system to be able to do.

Steven Lane
Okay. I think that's exactly what we want. Sorry. I'm trying to capture that in the notes. Perfect! Okay. ICD-10 will be added as an allowable standard. All right. Where do you want to go next, Michelle?

Michelle Schreiber
Okay, line seven. We had talked about the encounter disposition and the discharge disposition. We would like to formally recommend the discharge disposition just from the hospital, to start there. We recognize in future years we would need more.

Al Taylor
Which line again, Michelle?

Steven Lane
Seven.

Michelle Schreiber
I'm on seven. I have the spreadsheet open in front of me.

Steven Lane
What we had jotted down as a recommendation last time is include in version two a requirement for encounter disposition for hospital and ED encounters. Signal that this should be included for long-term care facilities when possible.

Michelle Schreiber
Okay. We're good.

Steven Lane
You're comfortable with that, Michelle?

Michelle Schreiber
Yes.

Steven Lane

Does anyone on the Task Force have any objection to that?

Leslie Kelly Hall
I just have a question, Michelle. On ED encounters, we are talking about short stay, observations stay, as well as elopements and then also discharge to the hospital, correct?

Michelle Schreiber
I caught the hospital. I caught the ED. Then you said something about short stay and observation and something else.

Leslie Kelly Hall
Yeah. Short stay, observation stays, elopement, and then also admit to the hospital.

Michelle Schreiber
Correct.

Leslie Kelly Hall
Okay. Thank you. I am just clarifying.

Michelle Schreiber
Although, this is just –

Steven Lane
There was another comment. Feel free to use the hand raising feature, please. Sorry, Michelle. Go ahead.

Michelle Schreiber
No, that's okay. The next is line eight.

Steven Lane
Wait. Before we leave line seven, Dan has his hand up.

Leslie Kelly Hall
Yep.

Daniel Vreeman
Thanks. Sorry. I'm reviewing the data element. I just want to be clear. The implication for the applicable standard of discharge disposition is simply the HL7 code system. Is that true or is there also a separate encounter location? I think we had some discussion about the difference between these kinds of things. I just want to be clear about the coding system that we're recommending if we move this forward.

Steven Lane
Before I ask Al to comment on that, I will point out that Leslie added column P to the spreadsheet, where the applicable standards were listed. Leslie, not being a standards expert per se or claiming to be one, has invited people to comment on the standards. I think this is sort of a copy paste from the website. Al, do you want to comment on the question?

Al Taylor

I would need to know – Adding an HL7 code system is a little bit of a departure from what we have done in the past. Defined as a code system, that could work. Something that we would have to look at if we were to require that particular code system of discharge disposition – it's like a value set but I think it is called a code system in HL7. That is fine to recommend that. If it seems like there are difficulties with adding an HL7 value set or an HL7 code system, it will probably mean that we just wouldn't have a required standard, an applicable standard. That's fine to put that forward.

Steven Lane
Please clarify what would be the specific recommendation, Dan.

Daniel Vreeman
If the stated recommendation is to require the HL7 code system called discharge disposition, if that applicable standard for testing, it would mean that the discharge disposition would have to come out of that code system. If we test it rigorously, we will validate that it came out of that code system. Previously, all of the other applicable standards are other c. Obviously, HL7 is an STO. I think that discharge disposition is constrained to SNOMED. I might be wrong on that. I'd like to have a look and see what the content is. I think that is fine to put that forward. If the intent is to constrain it to the HL7 code system, then that is something that we would have to look at to see if that is a feasible approach versus just putting something that represents the disposition in the disposition field.

Leslie Kelly Hall
Hans has a comment to add.

Steven Lane
I just wanted to clarify Dan's recommendation. Dan, is your recommendation that we do specify the HL7 code system as the applicable standard for discharge disposition?

Daniel Vreeman
I am cross referencing to see right now if it is what's bound in the US Core profile. Maybe Hans has that answer. I would recommend that, precisely because I feel that it is more helpful to have a applicable standard rather than none when we bring a new data element forward. I appreciate Al's point that there might be some additional evaluation and consideration of an HL7 code system. However, at this point I would support the recommendation to include the coding system as proposed in the data element.

Steven Lane
Hans?

Hans Buitendijk
Good morning. I just looked at and I put in the chat the link to currently what the list is that FHIR US Core in its latest build has. It's a must support. It is listed as an example binding. It is not necessarily tied to just that but frequently what happens is that those are the ones that support it. I would still have to double check version two ADT messages where typically these one are widely used. I just want to double check that it is the same as what's used there, which would mean everybody pretty much is using that. That is the one I have not had a chance to look at yet to see what we do in version two because that's operational everywhere. That's the likely one. I need to check with CCDA, but it's example which means it's not externally.

Steven Lane
Okay. Anybody uncomfortable with leaving our recommendation on this one as a recommendation that the HL7 code system be leveraged as the applicable data? All right. Hans, if you have additional information on that, just let us know. Okay, Michelle, I want to keep going through your list and get to a conclusion.

Michelle Schreiber
Okay. The next –

Al Taylor
Steven, my whole system I think is frozen right now. I think I'm going to have to reboot, so bear with me. Maybe somebody can cover for now.

Steven Lane
Thank you so much. I think the most important thing is for folks to follow along themselves so they can size and scroll as need be. It's hard on your display in any case. Michelle?

Michelle Schreiber
The next I have is on line eight, which is encounter location. I think we may have closed this out last time. Our recommendation is location only within a hospital. This is not including an address. It would be for ICU, ED, and NICU.

Leslie Kelly Hall
Just to clarify, this is really the service location within a hospital versus the hospital location.

Michelle Schreiber
That is correct.

Leslie Kelly Hall
Okay.

Michelle Schreiber
It seems like it was covered in the type, hospitals **[inaudible] [00:18:44]** what have you. I believe that is covered in type.

Leslie Kelly Hall
Yep. Okay. Thank you.

Steven Lane
Okay. Let me get this right in the Google Doc. Okay. We are on row eight, encounter location. I am adding your comment that you just included, but our recommendation is leave as a level two and encourage industry to work on this for a future version of the USCDI? Correct?

Michelle Schreiber
Yes, agree. Correct.

Leslie Kelly Hall
So, not including ICU, ED, and NICU?

Michelle Schreiber
No, that's it.

Leslie Kelly Hall
Correct. Okay, just clarifying.

Steven Lane
All right. Anyone else have any questions about that recommendation on row eight? Perfect.

Michelle Schreiber
The next one, I am trying to find the row.

Steven Lane
Actually, Michelle, before we leave – I'm sorry. I realized that on row seven we did not set a priority as a Task Force, which I'd like to do. Then we can go back as well. We suggested just roughly prioritizing **[inaudible] [00:20:13]** for each of these as we prepare our comments for the encounter disposition inclusion in version two. Does anybody feel it would be a one, a two, or a three? Personally, I think CMS's recommendation makes it a pretty high priority for us so I would tend to give it a one at this moment. Does anyone feel differently? All right. Great. I am sorry, Michelle, can we go back to the first one we discussed, the problem list with ICD-10? Which, Mark, was on row 30 something?

Michelle Schreiber
43 I think it was.

Mark Savage
43.

Steven Lane
43, yes. This spreadsheet is way too long. Okay. Again, prioritization, I think we are all pretty comfortable with this as a good thing to do. Leave it as a one? All right, I am seeing two heads nodding and hearing nothing. Let's go back up, Michelle. Sorry to make you jump around like that. We were on row – Where did you want to go next?

Michelle Schreiber
I want to go to the identification for the identifier. I think that we had closed out 10. We had closed out, I thought, 12, the facility organization. That is just the CCM number. There was the question of the identifier MBI, the Medicare beneficiary, and we had proposed that. There was some conversation that in the past people had wanted that but there was an issue not to do it. We queried across CMS and others. We can't find a reason not to, but because there is this memory bank of there having been an issue, we would like to remove this one for further evaluation and study. We will not recommend the MBI. It was under identification. I am trying to find the line.

Mark Savage
Is that row 40?

Michelle Schreiber
I know it was in the 30s or something.

Steven Lane
Yes, 40, indeed. I was just using the sort function myself. 40 is under data classification demographics, data elements patient ID and Medicare patient ID, MBI.

Michelle Schreiber
We changed it to recommendation in v3, but I wanted –

Steven Lane
Yes. I see that. Okay. Thank you. Does anyone have any questions or concerns about that?

Leslie Kelly Hall
This is Leslie. I think Clem also pointed out that this is something that is highly valuable and used and helpful to coordinate identities across multiple health systems and beyond. It seems – I guess I do not understand why not. Mark has his hand up as well, so I'll leave it there and pass it on to Mark.

Michelle Schreiber
The only reason why it's not is we've heard from others that there were problems with this in the past. We wanted to investigate what those might be. I couldn't come across anyone who said not to at CMS.

Michael Berry
So, Steven, I think I'd recommend that we make this pending and do a little more investigation first before making a decision.

Steven Lane
Right, we –

John Kilbourne
This is John. My memory is that there was a law, not even a rule, a law, that said that we will not use patient identifiers. That's just a very vague memory but it was a big deal because it was a law.

Michelle Schreiber
Yeah. That's just it. There are some people who have memories around this. I can't find it. We can't find it, but we would like to table this pending investigation.

Steven Lane
Yeah. There actually is a law that continues to float around the Federal Government that prevents the use of federal funds for the development of a universal patient identifier. That's pretty distinct from the question of where the Medicare Patient ID is going to be part of the USCDI. Medicare Patient ID is an identifier that exists for a certain subset of patients. We could certainly suggest including it. It's a political issue around people's perception of what supports patient privacy that we're not going to solve here. I don't think that would prevent us from suggesting this for version two. Al, do you feel differently?

Mark Savage
I don't think the political issue is around the Medicare identifier.

Steven Lane
No.

Mark Savage
I think it's around – so, there's no political…Okay.

Steven Lane
Agreed.

Leslie Kelly Hall
Maybe **[inudible] [00:25:23]** of service with Medicare. Anyone who is seeing a Medicare patient does have to collect that information. It's already prevalent.

Steven Lane
Al?

Al Taylor
As some of you may know, one of the data elements that was submitted for addition to the USCDI v2 is patient identifier. That is a lot closer to the concept of unique patient identifier, which is specifically prohibited. We have gotten confirmation recently, explicitly from the office of the General Counsel, that would not be acceptable. That would be in violation of that law. I think the question that maybe would change the framing – I can get verification about whether or not Medicaid Benefit ID number would qualify as a unique patient identifier versus simply a policy number. To me, it's a specific kind of policy number, but a policy number versus a patient identifier might be enough of a distinction to allow something like that to go through. I'm asking that specific question right now to the people that have more knowledge of what the ODC ruling was. It is possible the MBI – Michelle, correct me if I'm wrong. The MBI is an insurance number.

Michelle Schreiber
Correct.

Al Taylor
It's an insurance number related to a patient as opposed to a unique identifier.

Leslie Kelly Hall
It is a membership number. I have my unique identifier for my driver's license, but I still have an insurance card. It's an identity in that it's a member number as any other payor.

Michelle Schreiber
I mean, if the issue was also around the unique patient identifier, you are right. We could not do that. I'm told that we could not address that. The MBI is something that does exist. We would favor it, but we are pulling it back for tabling because there are these underlying questions. I could not find anyone at CMS who didn't think we could include it, but there are these underlying questions that we just wanted to do more investigation around.

Steven Lane
All right. Again, others can also suggest this as something that we advance for version two. As we said, Clem has suggested this. We appreciate the CMS position. Does anyone, including Clem, want to make a recommendation that we either do or don't include this in our report to HITAC?

Clement McDonald
Well, I'll just restate it. I think we should include it. I think all of these negatives are just confusion about what the rules really are. This is an existing number. It's nothing we are creating new. We just want to put it in the communication.

Leslie Kelly Hall
I would echo this and also for transfers to long-term post-acute care and referrals. This is a big deal that can eliminate confusion in the transitions of care as well as across multiple health systems.

Al Taylor
From ONC's perspective, if this goes forward, we will apply the test that we have applied to every other patient identifier concept. We will take that into consideration. If the Task Force submits something that our Office of General Counsel says we can't do, then we won't do it. If their recommendation is to do something that OGC says we can do, we consider it. I think it is fine to go forward with it as a recommendation and then we will do what we need to do with everything that we add, and figure it out from there.

Steven Lane
All right. I have a motion to include this in v2. Does anyone object to that? We're not going to do full Robert's Rules, but I want to make sure that we capture any dissenting views. Okay, good. We will leave it at that. Michelle, thank you for bringing this forward. We will leave your name attached to it, but it doesn't really matter because it is going to be a Task Force recommendation.

Michelle Schreiber
That's fine.

Steven Lane
All right. Michelle, do you have any more?

Michelle Schreiber
Just a couple more.

Steven Lane
Wait, wait! Before we leave that one, I'm sorry. Let me point out in column N that we've been told by our experts that US Core does not include this explicitly as an identifier type and CDA does not explicitly list it as an identifier type. It is not certification tested. Does that dissuade anyone from our Task Force recommending it? I'm specifically interested in Ricky and Hans' views.

Leslie Kelly Hall
Hans, that's an identity not for member number with a payor, correct? Although, I've talked about a Medicare patient ID, it is really the member number.

Hans Buitendijk
That is fair. Let me double check. It has typically been thought of as a patient identifier as much as that you're right, it is a member identifier for the Medicare insurance. So, let me double check whether there is another spot that it might have been that I overlooked.

Steven Lane

Thank you, Hans. Any concerns from the vendor perspective, either Hans or Sasha? Any implementation challenges that we need to be aware of?

Sasha TerMaat
I do not have any to call out offhand, no.

Hans Buitendijk
If it is not considered the patient identifier but it is considered a member identifier, then we might run into some challenges with the amount of payor coverage information that is currently in US Core. That is currently not really addressed in US Core.

Clement McDonald
Well, I don't think anything that was said should stop us from trying it.

Hans Buitendijk
It is identified as common use. If the criteria is that minimum or no change from existing US Core or CCDA, I think if that were considered a member identifier, I think this is trying to clearly indicate that there is data in UCDI that is not "clinical" per se in nature. It becomes more financial administrative. How do we start to recognize that and begin to include that, which is a somewhat bigger step in some areas to start to pick that up? I'm not saying –

Ricky Bloomfield
This is Ricky.

Hans Buitendijk
Go ahead. I'm sorry.

Ricky Bloomfield
Sorry. You could potentially get creative here and put it in the patient resource. There is an identifier field and that is generic. You can include any identifier there. It just needs a specific URI. I don't know if a URI has been defined for the Medicare Patient Identifier, but that could be done independent of the US Core guide itself and potentially included there. I guess the question is whether the patient resource is the right place for this or if you would rather have it live somewhere else. That seems like it may be a separate discussion than whether or not it should be included. It seems like there are some pathways for it to be included, potentially.

Steven Lane
In terms of the timing, if we suggest including this in v2 and the ONC takes our word for it and does so, does that give enough time for the FTOs and the vendors to figure out how to share it, or is this just one of as we have already in USCDI version one where we don't have all of that level of detail worked out? We just say if you've got, share it however you can.

Ricky Bloomfield
Yeah. I think there are definitely a number of open questions. Primarily, where should this be shared? I think that would require additional discussion. Also, the question of whether the vendors can map this in the data that they have or if the expectation is that this would primarily come from Medicare itself? I don't have an answer to those questions.

Steven Lane
I appreciate that. I am asking simply is the lack of answers to those questions, is that a reason for us not to support this?

Clement McDonald
I don't think so.

Steven Lane
Okay.

Hans Buitendijk
I think the downside potentially is if the conclusion is that it truly should not be a patient-level identifier as in patient resource, that would cause challenges in the meantime if we started to use that. There is a very interesting debate that can be had behind it. MBI is being collected. It is being used if you want to get a claim. It's not that it is not around. If we need to have the answer today, I would be a little bit hesitant. On the other hand, if we have until next week, we can just get a feeler out to make sure that there is a reasonable sense that patient is the way to go. Anything beyond that would be more substantial enhancements to US Core to make it support.

Steven Lane
Okay. I'm going to this one as yellow for us to come back to it. I really appreciate Hans and others digging in, but I think – Unless someone objects, I will put this as a priority two given the persistent questions. Not that we even know how we are going to use these priorities, but we will use them somehow before we are done. We will come back to this one. Okay, Michelle, where do you want to take us next?

Michelle Schreiber
All right. We took a lot of our requests you will see in rows 20 to version three. There are a couple more for us to talk about. One is a correction of what we put on the table. That is line 36, the diagnostic steps and exams with results. We do recommend inclusion of some of these in version 2. I am sorry for column I. We do have a short list of maybe a starter group that CMS uses frequently, in particular for cardiology studies, EKGs, Echos, pulmonary function studies, and bone density. We have those in **[inaudible] [00:36:43].**

Steven Lane
You use these frequently for quality measures?

Michelle Schreiber
Right.

Steven Lane
All right.

Clement McDonald
Clinicians use them frequently too.

Steven Lane
Yes, indeed.

Michelle Schreiber
From a patient point of view, these are essential. Clinicians use these all of the time. Patients look for these results.

Steven Lane
All right. Again, the list as you included in 36K is mammogram, colonoscopy, DEXA, Echocardiograms including ejection fraction, and PFTs.

Michelle Schreiber
Correct.

Steven Lane
I think this is very consistent with where our discussion was a couple of weeks back on the idea of coming up with a shortlist to start this process, knowing in the future this could and should expand to include other diagnostic studies and exams with results.

Clement McDonald
Steve, could I weigh in?

Steven Lane
Actually, Clem, raise your hand and we'll let Sasha go first.

Clement McDonald
Okay.

Sasha TerMaat
I just had a question. I know it's come up in other contexts where we've talked about whether things we might add to USCDI would be applicable to all products pursuing certification to USCDI. I guess with some of these scans, again, would we expect that every product that achieved certification would be able to document all of these types of diagnostic results? Or would some products be sort of capturing them and others would be viewing them like if they were received from another system? I just don't want us to accidentally sort of require something that would be inapplicable to all products in the market by inclusion in USCDI before we figure out some of the scoping considerations.

Steven Lane
Okay. I have captured your question. Clem, you can go ahead and then we'll ask Al to comment.

Clement McDonald
Yeah. Just one more. Glaucoma causes blindness. There is a simple measure, the telemetry, and they actually requested that. It was one of the things requested in the last comment period from the International Institute of Ophthalmology. It's so easy. There is right and left eye. It's a pressure. You want quality. You want to kind of make sure that people are doing it as people get older, or if they are following their medicine. I would just beg for one littler, tiny, itsy, bitsy more, two more fields.

Steven Lane
Okay. Al, do you want to respond to the questions on the table?

Al Taylor
To Sasha's point, to be able to capture or access or exchange this information is certainly one of the key factors in our decision about whether or not something can be or should be added to USCDI. Depending on how specific we make this recommendation, it could be more or less applicable to more systems. I think that this would be the kind of feedback that we would like to see before we made a decision about whether or not it should be added. Is it added only for in patient? It is only added for outpatient? Is it only added for observation or what? If it is more generic to be able to capture more diagnostic studies, then it might be more applicable. That would just be something that would go into the calculus of adding it or not.

Steven Lane
Actually, Al, I think the question is a little more generic, which is to say we keep circling back to this question. What exactly does it mean when a data element is included in USCDI? Does it mean that every certified system has to have the ability to receive and hold the data, and presumably display it to users? Or does it mean that every system has to be able to be built so as to capture the data? Again, if you have got a pediatric EHR, or if you have got a specialty EHR that you built for dermatology and we include left eye pressure, does the dermatology system need to have a screen for a dermatologist to collect a left eye pressure or does that system just need to have the ability to accept left eye pressure if it is sent by another system and stick is somewhere and make it available to its users? I think that is the question.

Al Taylor
Yeah. We get that. That is a very frequent question. What it means is USCDI is in seven or eight of our certification criteria. It must include in API, must include it in certain CCDAs all of the data elements that are contained within USCDI. Right? We site USCDI in these criteria. What it means is that a system that is certified to those criteria must be able to capture and exchange using that particular certification function, those data elements. For example, if a dermatology specific system is certified with v1 for transitions of care, it would have to produce a CCDA that would be able to capture that data element of interocular pressure and provide and compile it into a transitions of care CCDA. That is specifically what that means. If that certified system is certified to the criteria that requires USCDI, then yes, it would have to do that.

Steven Lane
Okay.

Leslie Kelly Hall
Clem has another question.

Steven Lane
Go ahead, Clem.

Clement McDonald
Well, it's just we agonize over all of this stuff while physicians are going without it. What do we do with labs? Why don't we just do the same rules as labs. They're all observations and have a very similar structure. What if we just apply the same rule to these as we do to labs? I don't know what that rule is in practice. It's just from a master file. It should just be a change in a master file, not a whole constructed specific data structure for each of these tests.

Leslie Kelly Hall

Daniel has a comment as well. Daniel?

Daniel Vreeman
Yeah. Thank you. I was going to build on what Clem said. To be clear, to produce a CCDA or something in this context effectively means to produce a results section, which might have a bunch of stuff in it including all kinds of tests and so forth. It's not as if there needs to be a particular filed with a term for a pulmonary function test in every record. It just means it has to produce a section that could be blank if there were none but has coded diagnostic test results. I think it would be a good thing to have that.

Steven Lane
Al, do you see it differently?

Al Taylor
No, I think that – I agree that this is one of the things that we considered. We had considered a broader concept such as observation. We actually had considered diagnostic studies, which is more generic than diagnostic imaging or diagnostic labs. We had considered those concepts to be added to draft v2. It is still a reasonable recommendation and I understand the value of having the ability to capture that. I think that every system has the ability to capture a vast variety of observations, including the ones that are listed here.

Leslie Kelly Hall
Sasha and Hans have something to add as well too, when you're finished. Sorry to interrupt.

Al Taylor
I'm finished but I didn't hear what you asked.

Leslie Kelly Hall
I'm sorry. Sasha and Hans both have a comment to add to this. Sasha, do you want to go?

Sasha TerMaat
This is Sasha. I will defer to Hans since he is deeper into this than I am. My concern is just that some type of the diagnostic studies have quite specialized reports to express their output. I don't know that that those – While some of them could be generalized in the way that Dan and Clem describe, I'm not sure all of the examples that Michelle listed would lend themselves to that. It might require further follow up before we make a recommendation.

Leslie Kelly Hall
Hans?

Hans Buitendijk
Yeah, I was going to say pretty much the same as Sasha. I'll highlight that conceptually these are indeed – I have no disagreement with Clem and Dan that these are grounded primarily in observation. However, there is that variety out there. We have seen in FHIR US Core that there are variations that are helpful to subsequently profile. Currently, there are profiles defined in US Core that are very specific as a result. A more general observation or otherwise are not there. In order to start to do this, the suggestion that some have considered is to focus on the smaller group that are more clearly agreed to, that at least the vocabulary is there. That there will be an agreement but the actual structure in which that is being expressed, given

the variety of it, where are there groupings that need more information, less information? Is some core set of data sufficient across the board? That needs a little bit more work. Yes, in CCDA there is a results section and yes, in FHIR there is observation. However, in US Core or in some of the implementation guides, there is more around it. What is the minimum data set that you need to wrap around each one of those? What is the vocabulary to use? That has not been as clearly fleshed out. It would require work to get that guidance. They might need a smaller, much more focused initial set and then figure out how to do it.

Al Taylor
Hans, the smaller, more focused set would be how we would implement testing. It would be a smaller set of data that would have to be incorporated and reproduced in a report. That would be how we could implement that small focus. I did want to note that some of the examples that are in column K I think may already be covered by diagnostic imagining report. When making a specific recommendation about what scope of the diagnostic studies is supposed to be included, I just would recommend making sure that –

Steven Lane
That is a really good point, Al. Right. Mammogram and DEXA are clearly imaging studies, so would not need to be included in this short list. That is helpful. I don't think you could necessarily – One could argue whether a cardiac Echocardiogram is an imaging study or not. Clearly, colonoscopy and PFT's are different. You make a good point that we could narrow this list by excluding mammography and DEXA because those are already included, which narrows it down to a pretty small number of additional diagnostic studies and exams with results that would need to be tested. Specifically, cardiac exams, which is related to echocardiograms, I think is really what you're asking for, Michelle, because of the linkage to ECQMs, PFTs –

Michelle Schreiber
There are a number of measures that link to echocardiogram, in particular the injection fraction.

Steven Lane
Okay. You're not talking about ECGs specifically which have the confusing aspect of having both an image and a report, and a number of discreet data elements. Correct? You're speaking about echocardiograms in particular.

Michelle Schreiber
Yeah. We would be okay tabling the conversations around EKGs. Echocardiograms and stress tests, something that shows left ventricular function I think would be important.

Leslie Kelly Hall
Hans and then Clem have further comments, but I realize we have **[inaudible] [00:51:13]** coming in a few minutes too, Steven. Two more comments from Hans and Clem.

Clement McDonald
Is it my turn? Well, all we do with 40 years is delay. I have to tell you; I'm not going to live another 40 years. What the hell are we doing? This is stuff everybody needs! We're talking about the imaging report all being narrative. These things have structure in them. I can send you codes for all of them. Now, people may choose other ones but there are codes set up for this. They are being sent in places for this. EKGs were sent by Marquette in a standard way for almost 40 years and now it is GE. They're still 80% of the market.

It is trivial! We did it in four days at **[inaudible] [00:51:58]** before computers were fast. It's frustrating to hear all of these reasons not to act.

Steven Lane
Okay. I love your passion, Clem, truly. Hans, last words before we try to finalize our position on this.

Hans Buitendijk
I have a question for Al. He indicated that we could narrow based on the different tests. I think as part of that, whatever the list that comes up, they have the clarity on what is the expectations for those that are not tested. I understand and I am completely in agreement with Clem's sentiments, and we worked together on a number of these for many years, decades it feels like. The question in the way that it is currently being described is can we get it and what is the extent to which we are going to say there is a generic structure in which you can put it? Do some of these require more specific structures based on what is happening? I'm quite familiar with how you can put it in generic solutions, which also has yielded different interpretations of how to do it. Where do we strike the balance on that? That is the challenge. What does it mean if it is not tested on what that means for certification and ongoing surveillance? It would be helpful to understand that distinction.

Al Taylor
Hans, that was for me?

Hans Buitendijk
Yes, sorry.

Al Taylor
I just think because if we want this to be more useful to more people, then we would want it dialed back a little bit and be less specific. There are many different ways of representing an observation, if we were to go all the way to that level. There are many different ways, many different code systems, that could represent things that are considered observations and observation results as well. There is a balance between being permissive and requiring that a system is more permissive in being able to capture things like this. It's how specific do we get to say this system is certified in this function? Because we can't say a system has to be able to capture every conceivable observation. It's not feasible to build. It's not feasible to require.

Steven Lane
Okay. We're going to cut it off. Al, I'm going to cut you off there. We are going to go to public comments.

Public Comment (00:54:46)

Michael Berry
Thank you. Operator, can we please open up the line for public comments?

Operator
Yes. If you would like to make a comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your line from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star key. One moment while we hold for comments.

Steven Lane
Thank you. While we are waiting, I'm just going to tell the group that I am going to put a task priority two on the one that we just discussed because I think priority one is a no-brainer that we all agree with. Priority two is that there is still some persistent concern and disagreement. I will put that there. Public comments?

Operator
There are no comments at this time.

Steven Lane
Thank you so much. Thank you for this discussion, Mark.

Mark Savage
Sorry. I was taking it off of mute. Will we come back at the end and look at the priority numbers that we have assigned to sort of look at them collectively and holistically?

Steven Lane
That is my plan, yeah.

Mark Savage
Thank you.

Steven Lane
We will back up the ones and the twos, and the threes to determine our final recommendation.

Mark Savage
I'm asking because there may be some where there is some degree of uncertainty that we think are higher priority than some of the no-brainers that we've also talked about. We will be able to look at it then.

Steven Lane
Perfect. Thank you. All right. We are three minutes from the end. Michelle, did you have any others that you wanted to be sure we touched on?

Michelle Schreiber
We moved most things to v3 that we had. There are just a couple of comments. One is that we want to strongly support putting in implements of social determinants of health and think that is an extremely high priority. Two is we have online 31 orders that there is an order of class. Particularly, we would like to advocate for **[inaudible] [00:56:56]** end of life care, for example, palliative care, comfort care. I think that others had raised an issue like that. I do not see this one on the spreadsheet anymore. I think we may have closed this one. Finally, the insurance type, the all-payor coverage type. Everything else we moved to recommending for the future. We thank you, again.

Steven Lane
All right. Let's see if we can just capture that. Let's go to row 31 where we are talking about orders, types of orders for medical care services that CMS is recommending inclusion in c2. They specifically called out orders for referrals to palliative care, hospice, comfort care, as well as the DNI/DNR orders, which are distinct. Anyone want to make any comments about that, pro or con?

Leslie Kelly Hall
This is Leslie. That includes POLST and MOLST that are combined permissions of the patient? Where does advanced directives sit in there? The first question is POLST and MOLST orders. Is that included, Michelle?

Michelle Schreiber
If those are orders, then yes, Leslie. It is included. Advanced directives generally are not orders. They are documents. We are looking specifically at things that are ordered.

Leslie Kelly Hall
Okay. I know we don't have time. I would like to talk about this. I definitely support this and also would like to move up advanced directives. Because one without the other would be a push for medicalization only of end-of-life care, which is consistent with an order set versus the patient's voice which is the advanced directives. Those two, in my mind, are inextricable.

Steven Lane
Leslie, between now and the next meeting, I would dig into the advanced directives with regard to whether or not that has been submitted and where it was leveled. I think that is different than orders. We can come back to this one. It sounds like this would include POLST and MOLST because indeed those are orders.

Leslie Kelly Hall
Right.

Steven Lane
Let's come back to this. Thank you, everyone, for your time and attention today. We will be meeting on April 6th, the day after the applicability date for information blocking, which is very exciting. We will see you all there and hopefully see you later today at the ONC meeting.

Clement McDonald
Thank you.

Leslie Kelly Hall
Thank you, everyone.

Michelle Schreiber
Thank you.

Hans Buitendijk
Thank you.

Leslie Kelly Hall
Bye.

Adjourn (01:00:11)