Transcript

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

January 25, 2023 10:30 AM – 12 PM ET

VIRTUAL

Speakers

Name	Organization	Role
Sarah DeSilvey	**Gravity Project; Larner College of Medicine at the University of Vermont**	**Co-Chair**
Naresh Sundar Rajan	**CyncHealth**	**Co-Chair**
Pooja Babbrah	Point-of-Care Partners	Member
Shila Blend	North Dakota Health Information Network	Member
Ricky Bloomfield	Apple	Member
Hans Buitendijk	Oracle Health	Member
Christina Caraballo	HIMSS	Member
Grace Cordovano	Enlightening Results	Member
Raj Dash	College of American Pathologists	Member
Steven Eichner	Texas Department of State Health Services	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Steven Lane	Health Gorilla	Member
Hung Luu	Children's Health	Member
Anna McCollister	Individual	Member
Clem McDonald	National Library of Medicine	Member
Deven McGraw	Invitae Corporation	Member
Aaron Miri	Baptist Health	Member
Aaron Neinstein	UCSF Health	Member
Kikelomo Oshunkentan	Pegasystems	Member
Mark Savage	Savage & Savage LLC	Member
Shelly Spiro	Pharmacy HIT Collaborative	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Al Taylor	Office of the National Coordinator for Health Information Technology	ONC Staff Lead

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

Michael Berry
Good morning, everyone, and welcome to the HITAC Interoperability Standards Workgroup's first meeting of the year. We are glad that you could join us today. I am Mike Berry with ONC, and the designated federal officer of the HITAC and this workgroup. On behalf of ONC, I would like to thank all of our workgroup members for volunteering their time and expertise for this important work. A special thanks to our cochairs, Sarah DeSilvey and Naresh Sundar Rajan, for taking on this important role. All workgroup meetings are open to the public, and your feedback is welcomed, which can be typed in the Zoom chat feature throughout the meeting or can be made verbally during the public comment period that is scheduled at approximately 11:50 Eastern Time this morning. I would like to begin roll call of our workgroup members, so when I call your name, please indicate that you are here, and I will start with our cochairs. Sarah DeSilvey?

Sarah DeSilvey
Here.

Michael Berry
Naresh Sundar Rajan?

Naresh Sundar Rajan
Here.

Michael Berry
Pooja Babbrah?

Pooja Babbrah
Here.

Michael Berry
Shila Blend?

Shila Blend
Here.

Michael Berry
Ricky Bloomfield?

Ricky Bloomfield
Here.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Christina Caraballo?

Christina Caraballo
Good morning.

Michael Berry
Grace Cordovano?

Grace Cordovano
Good morning.

Michael Berry
Raj Dash?

Raj Dash
Here.

Michael Berry
Steve Eichner?

Steven Eichner
Good morning.

Michael Berry
Raj Godavarthi?

Raj Godavarthi
Good morning.

Michael Berry
Bryant Thomas Karras?

Bryant Thomas Karras
Present.

Michael Berry
Steven Lane?

Steven Lane
Good morning.

Michael Berry
Hung Luu?

Hung Luu
Good morning.

Michael Berry
Anna McCollister?

Anna McCollister
Good morning.

Michael Berry
Clem McDonald? Deven McGraw?

Deven McGraw
Hello, everyone.

Michael Berry
Aaron Miri?

Aaron Miri
Good morning.

Michael Berry
Aaron Neinstein? Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Good morning.

Michael Berry
Mark Savage?

Mark Savage
Good morning.

Michael Berry
And Shelly Spiro?

Shelly Spiro
Here.

Michael Berry
Thank you, everyone. Now, please join me in welcoming Sarah and Naresh for their opening remarks.

Workgroup Introductions (00:02:27)

Sarah DeSilvey
Greetings, everybody. My name is Sarah DeSilvey. I had my brief introduction at the HITAC the other day, but for the purposes of this work, I am just going to do a secondary introduction. So, I am a rural primary practitioner in Vermont, and I have the honor of being the Director of Terminology for the Gravity Project. We will do further introductions in a couple seconds, but I am looking forward to leaning into this work, and I wanted to state that as both Naresh and I are new, we really look forward to following the precedent and wisdom of the collective, and are really welcome to any ideas that the group might have to make sure that we get the charter of this next section right. Naresh?

Naresh Sundar Rajan
Thank you, Sarah. Good morning, everyone. This is Naresh. I am currently serving as Chief Data Officer for CyncHealth. I come from a health information technology informatics background, an informaticist by training, and I am looking forward to a lot of metadata standards development with USCDI. Back to you, Sarah.

Sarah DeSilvey
All right. So, Mike, if I am correct, we now do general introductions for the rest of the crew, correct?

Michael Berry
You can also review the agenda, and then we can go into the introductions of the workgroup members.

Sarah DeSilvey
That sounds great. I am so sorry, and thank you, everybody, for your guidance and patience. So, as the first meeting of our session through April, we have a huge section of the agenda. There are going to be brief introductions, but then we will review draft USCDI at the direction of our friend, Al Taylor. Prior to doing that, we are going to review the charge of this group, which is similar to prior groups, so there should be some comfort for people who have been here in the past, then we will open it up to public comment at the end, and then go forward with a brief planning session, really, again, building off of precedent to take us into our next weeks as we try to complete this work prior to April 12th. Next slide, please.

Again, this is our roster. Akin to introducing on the HITAC, we are going to give everybody 20 seconds to introduce themselves, their reason for being here, and the IS WG. Again, I did briefly introduce myself. I am Sarah DeSilvey. My area of expertise is social determinants of health data standards, including integration with social care taxonomies. In that role, I work as the Director of Terminology for the Gravity Project, but I also want to just state, as I mentioned prior to the call, my daily work is in rural family practice, so I also am here to represent the needs of rural clinicians and rural technology and its opportunities, to put it that way. I am now going to pass the mic off to my cochair Naresh, and then, again, every individual will have 20 seconds to introduce themselves so we can complete the introductions promptly and then transition into our next work. Naresh?

Naresh Sundar Rajan

Thank you, Sarah. I will just wrap it up quickly. Again, a bit around the work that I have done so far with CyncHealth, the statewide health information exchange for Nebraska and Iowa. We deal with multimillion HL7 messages on a daily basis that flow through our systems. Being able to adopt USCDI standards is one of the things we are working on currently. We make sure that data centers, specifically hospitals and facilities, are adhering to USCDI standards, so the work that we do here technically defines our interoperability on how our operational systems operate on a daily basis, and what we do with that data, and how governance and provenance eventually play a role in interoperability altogether. So, I am really looking forward, again, and I will pass it to the next person here. I will just go with Pooja here.

Pooja Babbrah
Great, thank you. So, I am Pooja Babbrah with Point-of-Care Partners. I am the pharmacy and PBM practice lead. We are a health IT consulting organization. In my background, I am here to represent pharmacy. I am not a pharmacist, but have been in the pharmacy industry for almost 30 years now. I started as a product manager, where we used to send out Palm Pilots to doctors to try to get them to e-prescribe, so I have been around the pharmacy space for many, many years, and I am looking forward to this. I am excited. I know there are a couple of us representing pharmacy, and I am excited to see that we will be tackling some of that work in this workgroup, so I am looking forward to working with you all.

Sarah DeSilvey
Next is Shila Blend. I just want to elevate some comments on the chat, just to make sure everybody is aware. I am really grateful for the continuity of the members of this workgroup. I am just notifying and reminding them that everything that happens in the chat is part of the public record, and just to note that as we put things in the chat, just because we want to be careful, as part of our federal regulatory work is part of it being publicly accessed, so, just note that. So, off to Shila.

Shila Blend
Good afternoon, everyone. I am Dr. Shila Blend. I work at North Dakota Health Information Network, which is a statewide HIE, so I also work with making sure hospitals are interoperable, sharing their information according to standards, and we also work closely with our state Department of Health and Labs. I am also interested in this group, as I recently completed my PhD last year with a focus on health systems and was using big data sets to gather from multiple hospitals to evaluate a system. So, this work interests me in many aspects, and I look forward to what we will achieve.

Sarah DeSilvey
Thank you, Shila. Ricky Bloomfield?

Ricky Bloomfield
Hi, everyone. This always feels a little bit like a reunion, so many old friends and hopefully new friends as well, so it is great to be here. I am a physician in internal medicine and pediatrics, and have a background in clinical informatics. I am at Apple, where I lead the clinical and health informatics work on the health software team, and so, I help with all the technologies and partnerships related to helping our users access their data, and so, I represent the consumer health perspective. One of the most exciting things, I think, here is in addition to helping our users access this is how we can help move the ecosystem forward, so I have been working on FHIR-related technologies since 2013, almost since the beginning of FHIR, when I

was at Duke University prior to joining Apple, and have seen a lot of growth and evolution, so it is really exciting to continue to push that work forward, and I look forward to working with you all.

Sarah DeSilvey
Thank you, Ricky. On to Hans.

Hans Buitendijk
Good morning. This is Hans Buitendijk. I am Director of Interoperability Strategy with Oracle, and with that, I am focusing a lot on a variety of interoperability initiatives in the industry, representing Oracle in that space and vice versa to bring that back. In the context of USCDI, we are particularly looking at ensuring that we have good opportunity to implement what is included in there with a variety of implementation guides that sit behind it. From that perspective, I am active in the EHRA, which is a number of EHR vendors that are looking at this very carefully, active in HL7, where I am participating in development in a variety of different workgroups and accelerators, and am part of the FHIR management group, so those are the different perspectives you will see me bring to the table here.

Sarah DeSilvey
Thank you, Hans. On to Christina.

Christina Caraballo
Hi, I am Christina Caraballo, Vice President of Informatics at HIMSS. At HIMSS, we are really working to transform the full global health ecosystem, so a lot of the work within HITAC and USCDI is core to our mission. As of January 1st, I am also the President of IHE USA. Thank you.

Sarah DeSilvey
Thank you, Christina. Grace?

Grace Cordovano
Good morning, everyone. I am Grace Cordovano, a board-certified patient advocate specializing in the oncology space. My day-to-day is working with patients and their families as they navigate their diagnosis and the fragmentation that is our healthcare system. I have previously served on the USCDI Taskforce and Interoperability Standards Workgroup, and I primarily am hoping to elevate and amplify the patient and care partner voice to ensure the unmet needs of patients and their families are raised and considered in the work that we are collaborating on here.

Sarah DeSilvey
Thank you so much, Grace. On to Raj.

Raj Dash
Hi there. I am a surgical and cytopathologist, as well as a clinical informaticist, at Duke Health. In this group today, I am serving in the capacity of a representative of the College of American Pathologists, having been on a number of their committees, including as past governor, and currently as chair of the Artificial Intelligence Committee, really representing the laboratory and pathology domain. Thank you.

Sarah DeSilvey

Thank you, Raj. On to Steven.

Steven Eichner
Good morning. My name is Steve Eichner. I am the health IT lead at the Department of State Health Services here in Texas. I have been at DSHS for about 15 years, working on interoperability since day one, looking at both interoperability between public health and provider systems as well as significant connectivity between public health and Medicaid. I also have a lot of expertise in rare diseases, rare disease organizations, and that world as well, and I am very happy to be here. Good morning.

Sarah DeSilvey
Thank you, Steven. On to Rajesh.

Rajesh Godavarthi
Good morning, everyone. So, I am coming from the clinical decision support background from MCG Heath, primarily working between payers and providers, using a guide lens and the patient data/clinical data to make the clinical decision support systems, and I also actually participate in HL7 groups under the FHIR accelerators. I am one of the co-leads on the prior auth space, the payers and providers recent CMS proposal how the data should be exchanged, with the patient being centered in the focus, so I am very excited to be part of this group to see what other future things we can do to improve things for the patient.

Sarah DeSilvey
Thank you, Rajesh. On to Bryant.

Bryant Thomas Karras
Hi. I am Bryant Thomas Karras. I am an internist focusing on infectious disease and public health. I am a biomedical engineer and did NLM NIH training in informatics back in the ‘90s, which is really making me feel old. I have worked with many of you on this call. For my career, I am known to be that voice for state, local, territorial, and tribal public health, but I practiced and implemented electronic medical record systems in three different health systems, so I get the pains of both sides of the fence, and I hope to be that voice here on our workgroup.

Sarah DeSilvey
Thank you, Bryant. On to Steven.

Steven Lane
Well, hello. It is nice to see so many familiar faces as well as new friends. I am a practicing family physician in suburban California, in Silicon Valley, and a clinical informaticist as well. I have happily served on all of the workgroups that have led up to this one in terms of shepherding the USCDI forward, along with Christina, who humbly did not mention that she helped to cochair the initial workgroups on this body of effort. I have a number of roles in the industry. In addition to HITAC, I am on the board of the Sequoia Project. I chair the Care Quality Steering Committee, I support the HL7 Da Vince Project, and try to keep my hands in with DirectTrust as well as doing some work here in California on the statewide data exchange framework. I was at Sutter Health for over 30 years, where I still practice, but for the past few months, I have taken on the role of Chief Medical Officer at Health Gorilla, which is a health information network and

platform that is in the process of applying to be one of the first QHINs under TEFCA, so I am pretty involved and very excited to be here to keep pushing USCDI forward.

Sarah DeSilvey
Thank you so much, Steven. On to Hung.

Hung Luu
Good morning. I am a hematopathologist by training, and I am an associate professor of pathology at UT Southwestern Medical Center here in Dallas, Texas, and I currently serve as Director of Clinical Pathology at a pediatric tertiary care institution, and so, I am representing laboratory, but also from a pediatric perspective. I have also been involved with the FDA SHIELD Initiative in supporting and moving laboratory data interoperability forward, and so, I am also bringing that perspective to this committee, and I have the great honor to have been on the prior iteration of this workgroup, and I am also a current HITAC member.

Sarah DeSilvey
Thank you so much. On to Anna.

Anna McCollister
Hi there. I am Anna McCollister. I apologize in advance, I have a cold, so I may have a coughing fit amidst this. I am an intermittent consultant. Currently, I work with different companies focused on day-to-day use and governance as well as patient engagement in different formats. I have a history of health information technology that started about 12 years ago, when, as a frustrated diabetes patient, I founded a company to do data analytics with the hope of using electronic health record data to begin identifying digital biomarkers and patterns that were not available to RCTs. After that, I was original co-PI for the All of Us program. I was one of the co-PIs for the Participant Technology Center, which was building out the technological capabilities to understand the science of sensors as well as engaging sensors through a digital interface.

In addition, I did a second startup which created a platform to crowdsource and design clinical research, and along the way, I was one of the early founders of the We Are Not Waiting movement, which is a white-hat patient hacker movement in the Type 1 diabetes space which played a pivotal role in helping to accelerate the rate of data standardization, data access, and interoperability in the Type 1 diabetes space. In terms of government things, I served on national quality forum committees, first endocrine, now chronic disease standing committees, for the past 12 years, and I was a member of the Deja Workgroup, which was under the Ryder Health IT Policy Committee, which helps advise the government on ways that the government should consider regulating **[inaudible] [00:18:51]** and, as an advocate, helped the push for the health IT informatics elements in the 21st Century CURES Act. I am also on the FDA Drugs and Devices committees and a few other things, but I am really happy to be here. My apologies for my voice.

Sarah DeSilvey
Anna, we are so glad you are here, and I think many of us are sick. From family medicine, I can report that that is the way it is these days. I do not believe Clem is with us today. I have not seen him yet in the attendance, so I am moving on to Deven.

Deven McGraw

I am Deven McGraw, the lead for data stewardship and data sharing at Invitae, which is a clinical genetic testing company. My particular areas of interest are around patients being able to access their data so they can use it and share it as they want to, including with caregivers, and also different data governance rules and standards. I was with the federal government for several years as the HIPAA lead, also the Acting Chief Privacy Officer at ONC. I do have a law degree, but I try to keep it at layperson's language and help to translate what some of these requirements and standards mean, both from the HIPAA, and Part 2, and Common Rule, and information-blocking space. I am looking forward to working with this group.

Sarah DeSilvey
Thank you, Deven. On to Aaron Miri.

Aaron Miri
Good morning. Aaron Miri, Senior Vice President and Chief Digital Officer for Baptist Health here in Jacksonville, Florida. I am also cochair of the HITAC. I have also served on a number of these committees over the years. Prior to the HITAC, I was appointed by the Obama administration to the Health IT Policy Committee. I am also prior chair of the HIMSS Public Policy Committee and current cochair of the CHIME Public Policy Committee. I serve on the board of directors for CommonWell. Prior to this, I served with Dr. Lane on the Sequoia Project board and a number of other initiatives across the industry. So, it is good to see you all again, good to work with you, and I am excited about this taskforce. Thank you.

Sarah DeSilvey
Thank you, Aaron. I believe Aaron Neinstein is not here today, so I will move on to Kikelomo.

Kikelomo Oshunkentan
Hi. I go by Dayo for short. It is easier.

Sarah DeSilvey
Thank you so much!

Kikelomo Oshunkentan
You are welcome, and the A is silent, just for those… It is kind of tricky. It does not look quite like it is spelled. But, I am boarded in internal medicine and served as a hospitalist for over two and a half decades with a master's in public health and an MBA from Wake Forest. I have a **[inaudible] [00:21:34]** of healthcare experience, both in the payer and provider worlds and healthcare consulting. I focused on really providing an integrated approach to the industry, with a focus on high-quality, cost-efficient care delivery models and a deep expertise and proficiency in hospital medicine, focusing on physician alignment and accountability for delivering quality metrics and exemplary patient outcomes.

Currently, in my role as Chief Medical Officer of Pegasystems, I am the voice of patients and clinical customers inside and outside of the Pega organization in terms of really trying to leverage my expertise to drive the direction of the clinical industry technology solutions to support healthcare systems, health plans, and life science organizations to drive better patient outcomes, health equity, and improve provider experience. So, I am glad to be here, and I look forward to collaborating with you all.

Sarah DeSilvey

Thank you, Dayo.

Kikelomo Oshunkentan
You are welcome.

Sarah DeSilvey
Moving on to Mark.

Mark Savage
Good morning. I am Mark Savage. It is so good to be with all of you again today. I have been on previous iterations of this workgroup. I am working on areas of passion, such as the Gravity Project on social determinants of health data standards and California statewide data exchange framework, going live in January 2024. I primarily take my north star as being individuals and communities in all of their diversity. I work on areas of patient access and engagement, shared care planning, health equity, health disparities, and patient-generated health data. Much more, I am trying to make the system work for everybody. Thanks so much.

Sarah DeSilvey
Thank you, Mark. On to Shelly.

Shelly Spiro
Good morning, everyone. I am Shelly Spiro. I have been a pharmacist for over 45 years. I have had many different aspects of pharmacy in pharmacy practice settings that I have been involved in, especially the long-term post-acute care, for the last 20 years. I am the Executive Director of the Pharmacy HIT Collaborative, a collaborative formed in 2010 by the National Pharmacy Associations to ensure that pharmacists that provide clinical services are integrated into the national health IT infrastructure. We oversee the value sets within the National Library of Medicine that pharmacists use.

We have over 120 value sets. We have been involved with SNOMED, LOINC, and CPT. We also are very active in HL7, and I have been involved in leadership at NCPDP. We have worked on projects for Gravity, bringing social determinants of health to pharmacists. We have worked on the Pharmacist's Electronic Care Plan, which is part of the e-care plan standards within NCPDP and HL7. We have also been involved in the MCC care plan, PASIO, and some of the newer areas, but we focus very much on standardizing vocabulary for the pharmacist profession. I am so glad to be involved in this. I have been following USCDI since its inception, and also the ONC and HITAC. Thank you.

IS WG Charge and Timelines (00:25:15)

Sarah DeSilvey
I just want to thank everyone for their introductions. I want to give a nod to the ONC members who are here today as well, and on behalf of Naresh, I just want to say as a new member of the group, it is an honor to see so many new faces and old friends, and I really look forward to the work we have ahead of us over the next couple months. I believe we are moving on to the next section. Again, thank you so much for all of your introductions and your vast expertise. And so, now we are briefly going to discuss the charge of our next few months, familiar to many of you who were on the IS WG in the past.

So, the overarching charge is to review and provide recommendations on draft USCDI Version 4. Again, my past participation in ISWD was as a public member, so I am honored to be here, but when you break it down, it is specifically drafting USCDI, evaluating draft USCDI V.4, and providing HITAC with recommendations on new data classes and elements from draft USCDI V.2 and any Level 2 data classes and elements not included in draft USCDI V.4. In order to be aligned with the timing of public comment, the work of our next months is due on April 12th, and so, that is the cadence and the finish line for our work over the next few months. Mike, that is all I was supposed to say on this slide, correct?

Michael Berry
Yes, it is. Al Taylor is up next to go over draft USCDI Version 4.

Sarah DeSilvey
Wonderful. So, what we are going to do is Al Taylor is going to come to the fore and help walk us through USCDI V.4, and then we are going to have a pause at the end of his presentation where we can ask any questions regarding the charge and how it applies to the documentation and specs that Al is running through next. Al?

Draft USCDI v4 Overview (00:27:22)

Al Taylor
Great. Thank you, Sarah, and I am glad to be here for another round of exciting development of USCDI. My name is Al Taylor. I am an OB/GYN by training. I have been at ONC now for seven or eight years, and I have been technical lead for USCDI since its inception, and I will be going over the content of draft V.4 and holding a discussion about the process for developing the final version of V.4, which we plan to publish in July. Next slide, please.

This is a really quick overview of USCDI. Most everybody here knows this already, but USCDI is the standardized set of health data classes and elements designed for interoperable health information exchange to be available by patients, providers, and other users of health data. It is a required part of ONC certification criteria, or at least USCDI Version 1 is at this current time, and what that means is that certified health IT has to be able to exchange the data elements in USCDI, and in addition to serving as the data set for patients and providers, USCDI can be used and referenced for other purposes of health data and health data exchange, including those that are not specified in our certification program. Next slide.

We had an open submission period from last summer until last fall, and during that period of time, we received… We have a system to submit data elements for consideration. I should start with that. Through participation by quite a few members of the public and stakeholder groups, we received a total of 145 different data elements for addition to USCDI, and the categories of the submissions are listed here, including the count, and in addition to new data element requests or recommendations, we received over 300 comments on existing data elements, and so, these data elements were submitted during the V.2/V.3 process, and these are recommendations to advance things in the USCDI that were not accepted into USCDI in previous versions, but the recommendations were to reconsider that.

And so, we are looking at just short of 500 different comments or recommendations, and based on those comments and recommendations for addition, we took the data elements that we felt were most mature and most ready and feasible for implementation and applied certain criteria to them in order to determine

what should be added to the next version of USCDI. The first four are what I would consider to be policy priorities, and those include health data that addresses behavioral health data, bringing that on par with the interoperability of primary care and other non-behavioral-health realms, looking to mitigate healthcare inequities and disparities along with serving the needs of underserved communities and also, as we have done in the past, addressing public health interoperability needs.

The last five of these criteria are more technical prioritizations, and what that means is in order for USCDI to be implementable by users and developers, the data elements that are included in USCDI have to be of a certain readiness to go, and they should not require long periods of time in order to develop those data elements in a way that they can be interoperable, so they need to be well represented in standards, be able to be implemented or integrated into the existing implementation guides for exchange, and also be able to be implemented or integrated into workflows in an efficient way.

So, based on these nine criteria, we evaluated Level 2 data elements, Level 2 being the most mature and most feasible for adoption, and based on these prioritization criteria, we proposed to add 20 new data elements to USCDI, including one new data class. I am going to pause and give folks an overview, but we did add one new data class, that being facility information, and then, we added additional data elements in these data classes. There are a couple of note, and I will go into them in a little bit more detail. We added new data elements in the goals data class related to the advance care planning process, specifically about capturing and exchanging patient preferences regarding things that are considered during that advance care planning process, so these treatment intervention preferences and care experiences preferences are two new data elements in draft V.4.

We also added three new specific health status assessment data elements in addition to the others that were already there, including alcohol and substance use, along with physical activity. We also added a number of different laboratory data elements to provide more detailed information about the labs and the specimens that are part of lab tests. In the medication data class, we added a number of different data elements last time around for V.3 that covered more about the dose of medications that are taken by patients.

These two new data elements are designed to be able to capture and exchange information about the actual medication that a patient is actually taking. This is the information that is elicited during the medication reconciliation process, and medication instructions are just like it sounds. It could be the prescription for medication, but it is how a patient is supposed to take it according to package direction or provider prescriptions. Medication adherence is how the patient is doing against those instructions, against those prescriptions, and so, those two things together applied to the other data that is available for medications give a better picture about what is actually being taken by a patient.

We also added two new data elements for new vital signs with average blood pressure, and the time of procedure is a data element that we feel could be applied to a number of different things that are related to procedures, including things like vaccine administration, medication administration, and laboratory processing times. Those sorts of procedures could be covered by this timing element that we have added to draft V.4. I am going to go through the next slide fairly quickly, but just to review what we did, we updated the standards for these data elements, and then provided what we thought was an appropriate definition and gave some specific examples of what is meant by this particular data element. So, this is the allergy

data element. The encounter identifier data element was the one new data element in the encounter information data class. So, the new data class is facility information, with three data elements, being the identifier, the facility type, and facility name. Next slide.

These are the two new goals that I talked about that address advanced care planning and patient preferences, and these examples differentiate between the different uses of these two different data elements. This certainly does not cover all of the components of what goes into advance care planning, but we felt like these two not only address this concept of the patient voice in expressing their preferences and capturing and exchanging those preferences for use down the road, but we thought it was a good place to start. Next slide.

There are three new health status assessments. These specific categories of health status assessments were added to the data class, and we felt like those were good specific ones to address not only some behavioral health concerns, but one related to substance use and alcohol use, and for that matter, physical activity affects behavioral health as well, so these were added to the health status assessment data class. Next slide. These are the first three of the data elements in laboratories that we added, and the next slide covers the ones related to specimens. Next slide, please.

These are the two new data elements in the medication data class, and this is where the definitions and some examples of what is meant by these two new data elements are. Next slide. I described the use of the timer procedure. It does not specify here which procedure functions are covered by this timing data element, and that was intentional in order to allow its use in multiple different settings. Next slide. This is the new one on vital signs that we added to USCDI. Obviously, average blood pressure can be calculated from existing diastolic and systolic blood pressure readings, but the average blood pressure itself is an independent variable in outcomes rather than individual blood pressure measurements, and so, we felt like it was valuable, and this actually was the data element that received the most and strongest support for addition to USCDI as a unique data element, even though electronic health records and other health IT certainly can calculate averages based on a string of numbers, but we felt like because it was an independent variable, it was valuable and should be added to draft V.4.

The next slide is a summary of the entire USCDI draft Version 4, and I wanted to point out a couple of things that I did not already cover. One is in health status assessments, we reclassified the SDOH assessment data element into the health status assessment. Because of its typical structure and typical standardization, it fit very well into the concept of these health status assessments that are also in the data class. There is what seems to be a new data class called medical devices, right here in the middle of your screen. This is actually a renamed data class that used to be called unique device identifier for implantable devices, which was really just the name of the single data element that was in it. Medical devices includes not just implantable devices, but applied devices and assistive devices, and that would not qualify. An implantable device does not have an FDA UDI unique identifier, but still, this makes room for future new data elements in the more generic medical devices data class, although we do not propose to add them at this time.

Originally, in all of the last versions of USCDI, we had a data class and data element called assessment and plan of treatment. That is in the bottom of the second-to-last column. The patient summary and plan replaces the assessment and plan of treatment data class, and we felt like that was appropriate because assessment and plan of treatment is really one particular area of a patient assessment. Anybody who has

opened a medical record or read a progress note knows that assessment and plan is a very standardized part of a particular record or encounter, but there is room for other sorts of summaries, things like care plans, which is one fairly prominent example. While we did not propose to add care plan as a new data element or data class, we felt like there was some future potential to have care plan be part of USCDI in the future as further development occurs. So, that is a summary of draft V.4. Move on to the next slide, please.

I mentioned this as we went through it, but in addition, as we have done in the past, each version will get an updated version of the applicable vocabulary standards that we cite, and these are the ones that are current as of publication of the draft V.4, then we anticipate updating when we move to final V.4. As long as we maintain these applicable standards, we would update to the most recent version, then we publish in July, so that varies based on each standard, but this is where we are at right now with that. Next slide, please.

We have seen this table before. If you have been to a meeting before with USCDI, this is a little bit of a complicated slide, but it talks about all of the interwoven parts of the process. We are somewhere in the middle of this slide during the public submission and ONC review process, so this submission process is ongoing, but it is during this period of time, the little orange box in the middle, where we are undergoing public review and feedback on draft V.4, including the HITAC recommendations, which we will integrate into what will become the final USCDI Version 4 later this year. Next slide, please.

I want to talk a little bit about the specific time gates that we are going through in this period between now and April 17th for the public and April 12th for the HITAC. We are open to public comments, and we will process the comments as they come in all the time, but we will process all the comments and make some internal decisions about what things ought to change as we publish the final version of USCDI Version 4. When we do publish V.4 in July, we will open up the USCDI V.5 submission process so new data element requests can be submitted. They actually can be submitted now, but we sort of focus on it while we are looking at what is going to go into V.4, so new submissions and comments on what we publish in V.4 will begin to be received starting in July.

Okay, so these are some details about the public comment period. Sarah has already covered the first two in the charges for the workgroup, but these are some specific areas within the draft V.4 data elements and the Level 2 data elements that we are looking for comments on. When we publish draft V.4, we also publish what we call the standards bulletin, and that is a little bit more of a narrative summary and narrative description of the process for developing draft V.4 and some specific reasons why we added the data elements, and then, also, during the part of the standards bulletin where we asked for feedback, we asked for focused feedback on the two data elements related to the advance care planning process, the treatment intervention and care experience preferences data elements, along with the ones related to the medication reconciliation data elements, that being medication adherence and instructions.

And then, because we proposed to have multi-use, multipurpose data elements at time of procedure, we are looking for feedback on that recommendation that we have made. So, these are areas that the public have been asked to focus on, along with the HITAC and the workgroup. I am going to turn it back over to Sarah for discussions and the process that the workgroup will take for managing the charges.

Sarah DeSilvey
Thank you so much, Al, for the overview of the content that applies to the charge that we reviewed prior. Of course, as we note, the public process mirrors our own process, so we are working in sync on that. I want to note that as Al was presenting, we had two members join, and I want to give them a moment before we head into discussion and a plan for this R period that mirrors past years. I want to briefly center Clem for his 20-minute introduction. Thank you for being here, Clem McDonald. If you can do your 20-minute introduction, although you are well known, that would be appreciated. Clem I am going to let you unmute yourself.

Clem McDonald
I did not understand what I am supposed to or allowed to do in 20 minutes.

Sarah DeSilvey
Thank you so much. So, Clem, everyone else gave their 20-second introduction.

Clem McDonald
Oh, 20-second.

Sarah DeSilvey
I said 20 minutes by mistake, and I got all kinds of sweet little messages that I was in error, so, my apologies. So, 20 seconds to the esteemed Clem McDonald, and then, Aaron Neinstein will be next.

Clem McDonald
So, I am the Chief Clinical Data Standards Officer from NLM. I have been involved in medical records and standards for 40 years or something like that, and I am really happy and pleased to be on this committee. That is all I need to say.

Sarah DeSilvey
Thank you so much, Clem. Aaron Neinstein?

Aaron Neinstein
Hi. I am very excited to be here with everyone. I had a question about our scope and how it intersects with USCDI Plus.

Sarah DeSilvey
It seems like that actually is a question to answer right now, so I am just going to pivot for one second. So, we wanted to give everybody who had joined late a moment to introduce themselves.

Aaron Neinstein
Oh, sorry, my apologies. Aaron Neinstein, UCSF. I am a practicing endocrinologist and our Vice President for Digital Health, and I am really excited to be part of this. My question can wait.

Sarah DeSilvey
Or not! So, now, we are going to briefly pivot into discussion on the charge, on what Al presented, and on our work plan, of which, Aaron, that question and a few others in the chat are 100% applicable. And so,

right now, before we kick off into the work plan, I just want to make sure that we have direct questions answered. And so, Aaron, your question is a good enough one to start with. So, your question is regarding on how our charge in the IS WG integrates with the work on USCDI Plus. Al, can you lead on that one?

Al Taylor
Of course. So, despite its name, USCDI Plus is a separate process that ONC started undertaking about a year ago, maybe a little bit more than a year ago, and what it does is build on the content of USCDI to address additional data needs of other use cases. We currently have USCDI Plus activities in public health that we work primarily with CDC on, and we also are doing work with CMS in the quality realm with USCDI Plus. It is a separate activity, but it starts with USCDI as the foundation, and the "Plus" indicates the delta between the data needs in these other realms that are not already part of USCDI. I hope that answers your question.

Aaron Neinstein
Al, just a follow-up on that. It seems like things that find their way into USCDI Plus might be candidates for consideration in USCDI. Is that part of the standard intake process or not?

Al Taylor
It is separate. It is possible that things eventually could migrate over to USCDI Plus, but there is not a one-to-one connection. The USCDI Plus starts with an engagement with federal agencies that have an interest in advancing these particular use cases that exceed USCDI Plus, and so, agencies have engaged with ONC to start the process, and so, that is how those particular areas get started.

Sarah DeSilvey
Aaron, did that answer your question?

Aaron Neinstein
Yes, thank you.

Sarah DeSilvey
Fantastic. So, again, we will be talking about the process we are going to be taking for completing our charge shortly, but I do want to make sure we are answering any general questions. The process will mirror last year's process, but I believe Steven had his hand up. I am going to do my best to call in turn. That is a little challenging. And then, there are also some comments from the chat that I want to just make sure everyone is reviewing. So, some people are commenting verbally and some people are putting really critical elements into the chat. I just want to give a nod to Steven Lane on his comment there. So, Steven Eichner?

Steven Eichner
Thank you so much, and Aaron, I very much appreciate your question. I had the same general question as well. I just think that we need to work collaboratively with ONC and the other federal partners to really come up with a good strategy for what fits in what bucket, as it were, and what label applies to what case, because the USCDI does not really refer to use cases per se, whereas the USCDI Plus is really getting a very clear understanding about how elements are developed for both and what compliance is necessary on vendors, healthcare providers, and other participating entities about how they meet the requirements of both elements. That is something that I think we really need to have some clear strategy on. It may not be the

direct scope of this workgroup to get there, but it may be a more general recommendation coming out that says there does need to be some change or a strategy that does link the two in a clear way.

Al Taylor
Steven, I just wanted to touch on this. Last year, we had a presentation on USCDI Plus in this workgroup, and perhaps we could have a presentation on it, but I just wanted to be really clear that the processes are separate. They are not linked, other than what is needed in a particular use case that is not in USCDI is a candidate for USCDI Plus. USCDI does deal with use cases, but the data elements that do get incorporated into USCDI have a broader applicability across multiple use cases, and the ones that are not included in USCDI may have a narrower focus or may be only applicable to a particular use case, which are then brought up, but it is a separate process, it is not directly linked, and at the cochairs' discretion, we can have a presentation by the USCDI team on it in the future.

Sarah DeSilvey
Thank you, Al. I believe we are moving on to Mark Savage, who has his hand up.

Mark Savage
Thank you. Can we go to Slide 13, please, on the prioritization criteria? I have sort of a structural question. I am wondering how these prioritization criteria applied to what are the new data elements and classes that came into USCDI V.4, and then, what are the Level 2 ones that did not make it into USCDI V.4. For example, last year, the workgroup recommended some pretty important data elements around gender identity. They worked through HITAC, HITAC made the recommendation to the national coordinator, they did not make it into V.4, and I certainly respect that, but to understand how these prioritization criteria apply to leave something at Level 2 and not get into V.4 and other things did may be a question that is better for the second phase of our work, when we are looking at Level 2. It is structural, understanding the big picture of how things got in and how other things that are important did not. Thanks.

Al Taylor
If we are going to look at the Level 2 data elements separately… Mark, it is hard to say exactly why. As we have said in the past, we have a limit to the number of data elements that we can add each time. It is not a fixed number, but there is a general limit because if we want these new versions to be adopted incrementally with each version as they become available, we cannot make it a huge list each time, so that is one thing. The ones that we did add fit into at least some of these prioritization criteria. There are definitely other ones that could fit into these prioritization criteria, but were not selected for a variety of different reasons.

Even though they might be Level 2, there might be some indication that there is some significant implementation burden or development burden with how to update an IG, like US CORE, and those sorts of things. Even though they are relatively mature, it might make it more difficult. And then, with the last of these data elements, this modest aggregate lift is what I was talking about as far as how there are only so many that we can add each time because we are asking people to adopt these voluntary updates to USCDI, and we are mindful that making too many changes all at once is not really tenable.

Sarah DeSilvey
Before we pivot to the next, first, Mark, I am hoping that answered your question.

Mark Savage
For the moment. Thank you.

Sarah DeSilvey
Okay. Before we go to Bryant, there is kind of an add-on question. I just want to note in the chat that Raj is elevating a question. I am a new member myself. Al, you talked about the how, but the who might be helpful to understand for further meetings, like the process of determination after recommendations from HITAC, because it looks like Raj in the chat is elevating who determined, not just how determined, and maybe that is an answer that can be appropriate when we dive into Level 2, but Al, I just wanted to note that that was one thing that might be helpful to new members.

Al Taylor
You say "the who." Can you be more specific?

Sarah DeSilvey
Raj has a comment in the chat, plus one to Mark's verbal comment. Who determined what remained included, if not the prior committee? That would be good to understand the process. Thank you, Mark. If there is a document that provides transparency, we would appreciate a link. So, after recommendations went through the IS WG to HITAC, how the process went after the fact is, I think, what new members are asking for understanding on.

Al Taylor
I will say that the ONC as a whole considers all of the recommendations by the HITAC by way of this committee, this workgroup, and makes determinations based on a variety of different factors, including policy priorities and national coordinator priorities, to determine which of those can and will be adopted. And so, I am going to lean on Mike to talk a little bit more about how ONC specifically deals with a general recommendation, any recommendation from the HITAC. It is a policy process that is a little over my pay grade.

Michael Berry
Al, I think you explained it well, that all HITAC recommendations that go to the national coordinator are considered, whether it is this subcommittee or any other subcommittee.

Sarah DeSilvey
I am going to hold space for an emerging understanding of that over the course of our charge. We will review the process we are following for review, which mirrors past years, going forward, which focuses first on USCDI V.4, the new data classes and changes, again, mirroring past workgroups. That is a comment in the chat. I just want to move now to some of the further questions. Bryant?

Bryant Thomas Karras
Thank you. This kind of builds on the conversation that has been going on in the chat. Al, I would love some clarity in standards that have not made the Level 2 list or that have not signaled that they are going to be incorporated in future versions. Is the Plus category the appropriate place for them to be redirected to? I will give two disparate examples. The prescription drug monitoring is not currently part of the USCDI core. The NCPDP space has been well established in that, but could this group make recommendations that we

would like convergence of formats and standards to promote interoperability and decrease burden of having to implement multiple different types of standards in a given institution?

And then, outside of the scope, perhaps, of HHS and ONC's reach, thinking about environmental testing and environmental test results where it is not a patient as that unit of analysis, various CDC groups have made cases for the use of USCDI Plus, but since there is not a strong signal that it would ever become included in the USCDI, there is a hesitancy, "Why should we invest in inclusion into that Plus category?", which, in part, leads to continued burden for institutions like public health that has to deal with both the clinical and the environmental spaces.

Al Taylor
Thanks, Bryant. Because of this concept of aggregate lists, the concept of the other technical priorities, along with a combination of the policy priorities that are listed here on this screen, I cannot say in particular why an individual data element was not added to USCDI. We add things to USCDI that have a generally broader applicability to not just patients and providers, but to other uses of the data, and so, I really cannot say specifically why one data element was not added because there are about 200 Level 2 data elements that were not added to draft V.4, and there are about 400 that are in the other levels that also were not considered for Level 2. They were not considered to be mature enough, broadly applicable enough, or implementable enough to be considered Level 2, which would then put them into consideration, but that is consideration based on all of these criteria, and things that are Level 2 could be considered, particularly if their breadth of applicability increases.

So, a new use case, a new federal reporting requirement, or a new healthcare priority brings these data elements that are Level 2, Level 1, or even at comment level into this higher-prominence category, so, work to develop those additional use cases, the additional maturity needed, are things that could be done. We will reevaluate Level 2 data elements in the future, but if there are no changes to a data element, no additional testing, no additional real-world use, no additional use cases, no additional federal reporting requirements, it is hard to say that any of those are going to just naturally or passively become better candidates for USCDI.

Sarah DeSilvey
Thank you, Al. I want to note that the veterans on the meeting are letting us know that it might be helpful to convert some of those brilliant answers into a whitepaper or fact sheet, given that it might be repeated over different iterations of IS WGs. That does seem like a smart thing to move toward to develop some common understanding and also save us answering the same questions over and over, so we can think about that as we go forward as part of our charge as well. I am going to now move to the next person. I am just going to note that we have until 11:50, and then it is public comment. I do want to save time to review the work plan, which mirrors past work plans and methods. You can see people are already mentioning the spreadsheets that are available on Google, but off to Anna.

Anna McCollister
Hi there. I think the idea of either a whitepaper or fact sheet of the process would be incredibly helpful. This is all somewhat confusing, trying to come up to speed and think about ways I can contribute meaningfully without asking a silly question, but one of the concerns that I have is, first of all, I am trying to get my head around the process by which the new data elements are proposed. I think that has been covered in prior

questions and the suggestion of the whitepaper. I am wondering if it is still possible to have additional elements proposed and if that is what the current period of public comment is all about, and I presume that those of us in this workgroup want the opportunity to address data elements that are not proposed or at least not highlighted as new data elements.

One of the things that I am concerned about and have been concerned about for quite some time, coming to this at the moment with my patient hat squarely on, is that all of these standards look interesting, but when I think about what the things are that are relevant in my clinical encounters, and just for context and reminder, I have Type 1 diabetes and all the microvascular complications of diabetes, which means I have kidney disease, eye disease, and nerve disease. That means I have to constantly take my blood sugar measurements through a continuous glucose monitor, I have to constantly check my blood pressure and my weight and hydration and other elements that are relevant to my kidney disease and the control of my kidney disease and hypertension throughout the time.

I have seen my nephrologist in person maybe once or twice since the pandemic began. I have not seen my endocrinologist in person since the pandemic began. All of that is happening via telehealth, which is incredibly convenient, but none of the vital signs and things like that that we are talking about as being important and included in this stuff are captured, so that means that none of my physicians have any record of my blood glucose on a day-to-day basis, blood pressure, weight, etc., which I would say are far more relevant to my clinical record, servicing my health, and even capturing it for real-world evidence than the biomarkers that get collected during bloodwork and lab tests. It is fascinating to me that so much of the stuff that is collected does not really seem to serve the interests of the patients and promote productive discussion with physicians. Even when I do see my physicians, I have to personally take several different printouts and medical devices and pull up several different apps from different providers to be able to give my physician that I am seeing at the time all of the data at hand.

So, I feel like we have spent a lot of money creating an informatics system focused on clinical encounters as opposed to attempting to capture real-world data that is far more relevant, especially for those of us with chronic diseases or long-term illness, and I would love to figure out what is the process by which… I know that I am not the only patient or, for that matter, provider who is concerned about that. What is the process that we are missing in terms of getting these elements added to the requirements for interoperability? I know that is a big question.

Al Taylor
I cannot address everything that you just said. There is not enough time to do that in this setting, but the process to add things that were not added before is well standardized at this point through the ONDEC system, the submission system for new data elements, and also commenting on other data elements that were not added in the past. So, that is established, anybody can do it, the HITAC can do it, individual members of HITAC can do it, and members of the general public can do it, and we encourage that at every step, and ONC also engages in more focused engagements with individuals or groups as to why a data element might not have been added, but that process is still available, and this workgroup is charged with making specific recommendations about what is in Level 2 that should be in V.4 or what is in draft V.4 that should not be in V.4. So, that is what the workgroup is charged with, but the public still has access to that comment process and submission process as well.

Anna McCollister
Can we also make recommendations for how to better engage people so that they know this is happening outside of the uber-nerdy circles that we all navigate in? And I consider myself to be a major nerd, so I do not mean that in any pejorative way towards anybody else on here.

Al Taylor
Of course.

Anna McCollister
In terms of the prior authorization criteria, one thing that I feel is always missing from all of these, whether it is FDA or whatever government agency, is there is a lot of concern about implementation burden on the developers or, in this case, health IT, EHR companies, and hospitals, but there is very little reference to the burden placed on patients and mitigating the burden placed on patients to basically serve as our own health information exchange and do all of the grunt work to facilitate our own care, so I would love to see things like that elevated in terms of prioritization criteria.

Al Taylor
It is a great recommendation. Although the charges are not as focused on process, it is certainly something that has come through in the past as far as a recommendation from the HITAC, but again, the charges are more focused on what was included and what was not included for this workgroup at this time.

Sarah DeSilvey
Thank you, Al, and thank you, Anna, and I look forward to having that conversation. I put this in the chat, but we are three minutes out from public comment, and I see that we have two more questions, but we also wanted to review the spreadsheets that have been mentioned in the chat in order to understand the place to do much of the asynchronous work, so I am a little torn about how to go forward. I am wondering if we can pull up the spreadsheets, Al, as I try to address some of those questions so that we can make use of time. Does that seem okay?

Al Taylor
Sure. Let me pull the spreadsheet up. So, the spreadsheet is just newly developed, and we have not added all of the members of the workgroup to the spreadsheets, and we will discuss the way that members should use this or can use it in the future, and during this process, we will go into that. Our next meeting is going to be pretty heavy into the process of using these spreadsheets, which is our primary means of capturing what will become recommendations for this workgroup.

Sarah DeSilvey
And we will have to go back to the slides, of course, when we return to public comment, but this is just an orientation. Thank you, Al.

Al Taylor
So, really quickly, this is a list of the data elements that are in draft V.4, a note and color coding as to what changed compared to Version 3. The applicable standards are just kind of there because that is part of the reference for the data element, and then, the following comment is a copy of last year's spreadsheet, just

to give you a baseline, and some of the content in these latter columns are not current. So, this is where we will capture recommendations.

We also have one from last year where the recommendations were made, and the justifications, and what led to the final recommendations. This spreadsheet will be directly editable by all the members and only the members, and it is from this that we develop the list of specific recommendations. And so, we will go through this. Once we get this set up, we will send out homework with links to these, including everybody sending their Google Doc email to Excel so they can get proper access to these. So, this spreadsheet was from last year, this spreadsheet is updated for this year with all the new data elements in it, but this is a really quick look at the way that we are going to be capturing the work that we are doing.

Sarah DeSilvey
I am going to direct some of the questions in the chat to direct emails to Al after the fact as we pivot to the public comment. It is time for public comment, and we want to make sure we stay on time with that.

Public Comment (01:19:47)

Michael Berry
All right, thanks, Sarah. We are going to open our meeting for public comments. If you are on Zoom and would like to make a comment, please use the hand-raise function, which is located on the Zoom toolbar at the bottom of your screen. If you are on the phone only, press *9 to raise your hand, and once called upon, press *6 to mute and unmute your line. Let's pause for a moment to see if anyone raises their hand. I am not seeing any hands raised, Sarah and Naresh, so I will turn it back to you. We will monitor this, and if anyone raises their hand, we will come back to that, so I will turn it back to you. Thank you.

Workgroup Work Planning (01:20:23)

Sarah DeSilvey
Wonderful. That being said, noting that if a public member wants to comment, we will pivot, but Shelly and Grace both had questions. Shelly if your question is still on target, would you like to ask it now?

Shelly Spiro
Sure. I put it in the chat. I will be traveling on two of the meeting dates, and I wanted to know which data classes or elements we will be discussing first, second, and third in terms of when the meetings will be. If that would be possible, that would be very helpful to assure that we know when we are going to be discussing which data class. In addition, I had a question about advance directives and patient preferences. I know advance directives are listed in Level 2. Transitions of care is something that both pharmacy and LTPAC is very focused on, and we want to make sure that the components of the data elements that are identified in PASIO, and I know we have cognitive and functional status already put in, but where do advance directives fall? I know they are in Level 2, but where are they going to fall in terms of patient preferences? Will we be looking at Splash? I know we have language in there, but what about speech and hearing, some of those areas that some of our folks, especially in the LTPAC setting or high-risk setting, have certain spatial preferences that we need to be aware of, especially during transitions of care?

Sarah DeSilvey

Thank you, Shelly. Regarding the process element, I can answer that. We had that discussion last night in a prep meeting for this call, recognizing the need to let the public know when we were addressing certain data classes. I hope to give more transparency to that in an email to the committee members after the meeting so that we can communicate because it is really important to have a plan that the community members can circle around. I am holding space for the advance directive comment to be addressed in future sessions. Grace?

Grace Cordovano
I am just trying to find a way to bring more clarity to the process, and there has been so much discussion about what was previously done. I do not know if this is a question for Al, but when we look at the USCDI website, we have done some work to improve clarity as to what the elements look like. We have added some symbols to flag certain things. I am wondering if there is a way that we can add another symbol to notate which elements may have been extensively discussed and recommended to HITAC, but did not make the cut, whether it is a little red dot or a purple triangle. Would that help in grounding new members and new workgroup teams that are working to try to review what Level 2 elements should be prioritized?

And then, I am also curious… We have these spreadsheets that we put substantial amounts of time into, both individually in small groups and in weekly meetings. For elements that maybe are flagged, then, with this new symbol, would new workgroups potentially have access to these spreadsheets as a reference document, if not making them fully public? Because the amount of time and wisdom that is invested in them is really of value, and as far as I know, we do not have access to previous workgroups' spreadsheet work.

Al Taylor
So, Grace, that is a really good idea. The HITAC recommendations from last year are public, and so, I think that might be a good thing for everybody to review. I do not think there is enough time in a meeting to go through it again. So, the recommendations, including all of the specific data elements that were addressed in those recommendations, are public. I think that we can make the past workgroup content for discussion points available to the workgroup, but I would defer to Mike Berry on that. I think that would help, as opposed to rehashing something that has been fully discussed and decided on in past workgroups, although we can change the recommendations this year. I think that would be a good idea so that we do not rehash things that we do not need to rehash, or maybe do not want to rehash.

Grace Cordovano
Could we link the previous HITAC recommendations in the new standards bulletin that comes out?

Al Taylor
Probably not, because that is working information from the workgroup. The HITAC workgroup's working papers are not within the scope of the standards bulletin.

Grace Cordovano
Okay, thank you.

Sarah DeSilvey
I just want to note we want to at least center on some upcoming meetings. So, first of all, thank you for all the brilliant comments of everyone who has been here before and everyone who is new. Naresh and I will

take these recommendations for process based on previous recommendations back to our planning meeting to make sure that we communicate a clear path for how to go forward in our charter and our work. Before we close, I just want to make sure everyone is aware of upcoming meetings because there is a shift. The February 8th meeting conflicts with HITAC, so we have shifted to February 7th. I believe that is the most significant thing on this slide to convey. Otherwise, we will be meeting regularly at this time on Wednesdays. There is just that shift for the 7th because of the conflict there. Any other final thoughts from ONC or others before we adjourn the meeting? First, I just want to say thank you for your graciousness for Naresh and my cochairing, as we are new to the IS WG. We are grateful for all the wisdom that precedes us, and we will be leaning heavily on it as we go forward in our work. Back to you, Mike and Al. Next slide.

Michael Berry
Thank you, everybody. We stand adjourned until next week. See you then, thank you.

Sarah DeSilvey
Thank you so much.

Adjourn (01:27:41)