Transcript

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

March 19, 2024, 10:00 – 11:30 AM ET

VIRTUAL

MEMBERS IN ATTENDANCE

Sarah DeSilvey, Gravity Project, Co-Chair
Steven (Ike) Eichner, Texas Department of State Health Services, Co-Chair
Pooja Babbrah, Point-of-Care Partners
Shila Blend, North Dakota Health Information Network
Ricky Bloomfield, Apple
Medell Briggs-Malonson, UCLA Health
Hans Buitendijk, Oracle Health
Keith Campbell, Food and Drug Administration
Christina Caraballo, HIMSS
Raj Dash, College of American Pathologists
Derek De Young, Epic
Rajesh Godavarthi, MCG Health, part of the Hearst Health network
Steven Lane, Health Gorilla
Hung Luu, Children's Health
Anna McCollister, Individual
Katrina Miller Parrish, Humana Health Insurance
Alex Mugge (& Traci Archibald), Centers for Medicare & Medicaid Services
Kikelomo Oshunkentan, Pegasystems
Rochelle Prosser, Orchid Healthcare Solutions
Mark Savage, Savage & Savage LLC
Shelly Spiro, Pharmacy Health Information Technology Collaborative
Zeynep Sumer-King, NewYork-Presbyterian
Naresh Sundar Rajan, CyncHealth

MEMBERS NOT IN ATTENDANCE

Grace Cordovano, Enlightening Results
Hannah Galvin, Cambridge Health Alliance
Jim Jirjis, Centers for Disease Control and Prevention
Lee Fleisher, University of Pennsylvania Perelman School of Medicine
Aaron Neinstein, Notable
Fillipe Southerland, Yardi Systems, Inc.

ONC STAFF

Wendy Noboa, Designated Federal Officer, ONC
Al Taylor, Office of Technology, ONC

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

Wendy Noboa
Good morning, everyone, and welcome to the Interoperability Standards Workgroup. I am Wendy Noboa with ONC, and I would like to thank you for joining us today. All workgroup meetings are open to the public and your feedback is welcome. Members of the public can type comments in the Zoom chat feature throughout the meeting or can make verbal comments during the public comment period scheduled towards the end of today's meeting. I will now begin roll call of the workgroup members.

If you hear your name, please indicate you are present. Let us start with the co-chairs. Sarah DeSilvey?

Sarah DeSilvey
I am here, good morning, everybody.

Wendy Noboa
Steven Eichner?

Steven Eichner
I am here.

Wendy Noboa
Pooja Babbrah?

Pooja Babbrah
Good morning. I am here.

Wendy Noboa
Shila Blend?

Shila Blend
Present.

Wendy Noboa
Ricky Bloomfield?

Ricky Bloomfield
Good morning.

Wendy Noboa
Medell Briggs-Malonson?

Medell Briggs-Malonson
Good morning, all.

Wendy Noboa

Hans Buitendijk?

Hans Buitendijk
Good morning.

Wendy Noboa
Keith Campbell?

Keith Campbell
Good morning.

Wendy Noboa
Christina Carballo?

Christina Caraballo
Good morning.

Wendy Noboa
Grace Cordovano? Raj Dash?

Raj Dash
Present.

Wendy Noboa
Derek De Young?

Derek De Young
Good morning.

Wendy Noboa
Lee Fleisher? Hannah Galvin will not be able to join us today. Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Wendy Noboa
Jim Jirjis? Steven Lane?

Steve Lane
Good morning.

Wendy Noboa
Hung Luu?

Hung Luu

Good morning.

Wendy Noboa
Anna McCollister?

Anna McCollister
Good morning.

Wendy Noboa
Katrina Miller Parrish?

Katrina Miller Parris
Good morning.

Wendy Noboa
Aaron Neinstein? Kikelomo Oshunkentan?

Kikelomo Oshunkentan
Good morning.

Wendy Noboa
Rochelle Prosser?

Rochelle Prosser
Good morning.

Wendy Noboa
Mark Savage?

Mark Savage
Good morning.

Wendy Noboa
Alex Mugge

Alex Mugge
Good morning.

Wendy Noboa
Fil Southerland? Shelly Spiro?

Shelly Spiro
Good morning.

Wendy Noboa

Zeynep Sumer-King?

Zeynep Sumer-King
Good morning.

Wendy Noboa
Naresh Sundar Rajan.

Naresh Sundar Rajan
Good morning.

Wendy Noboa
Good morning. That completes the roll call. Is there anybody I missed, or who just joined us?

Traci Archibald
This is Traci Archibald from the Centers for Medicare & Medicaid Services (CMS). I am in the Quality Measurement and Value-Based Incentives Group (QMVIG). I am here for Joel Andress, who has been here previously, and Michelle Schreiber.

Wendy Noboa
Traci, thank you. Please join me in welcoming Sarah and Ike for their opening remarks.

Opening Remarks (00:02:53)

Sarah DeSilvey
Good morning, everybody. We missed you last week even though I wrote in the chat it was nice to see so many of you in real life at Healthcare Information and Management Systems Society (HIMSS). The mission for these next weeks before we send our transmittal letter is to make sure we review any remaining Level 2 elements and finalize our recommendations. We really hope you are not getting overwhelmed by our emails urging content in the final recommendations section so we can all respond to it. We will continue to refine those recommendations over the course of next week, including today. Ike?

Steven Eichner
Just echoing what you said. As usual, you did a fantastic job. I look forward to getting some more stuff done today.

Sarah DeSilvey
All right, we can go to the agenda and make sure we all understand it. We are going to spend a little time looking at recommendations making sure we raise any concerns in the v.5 elements. I am committed and Ike is committed to making sure we rest very carefully on the Level 2 elements of note. We briefly touched upon them last time. I hope to even reserve a larger buffer than just that last chunk of time Level 2. We will go to public comment at 11:25. I do not think there are any comments. Next slide. Next slide. The charge by now is known to everybody. Our job is to review and provide recommendations on Draft United States Core Data for Interoperability (USCDI) v.5. This includes regulations on Draft v.5 elements and elevating any Level 2 elements. We are making good headway on that as we go forward. Next slide.

We are going to go to the spreadsheet now if we go to the next slide. We have briefly touched on all of the elements so far, which is good to know. Our job now is to move as many of these highlighted elements into green and put them to rest, so we can start finalizing the transmittal letter. We are already working on a draft of that transmittal letter to try to get ready because it is a lot of work to prepare it for anybody who has been in past Interoperability Standards Workgroups (IS WGs). Any other comments? Ike?

Steven Eichner
Nope.

Sarah DeSilvey
All right, next slide. We will rest here and then go to the spreadsheet briefly. Al, would you mind taking us there? Katrina?

Katrina Miller Parrish
If you do not mind while Al is getting the spreadsheet up, which I have had serious challenges trying to edit in there and not delete things. I was wondering what is the process to get our final recommendation. Is it a majority vote? What is it? Thanks.

Sarah DeSilvey
What we usually do is review the draft final regulations together these last weeks. This is partly why we wanted to have something to respond to and get to a point of consensus. Then we move the recommendations to the transmittal letter. Our final revisions happen in the transmittal letter itself. We do usually try to resolve any formal objections to consensus before we move forward and usually do not have too many at that time. Katrina, was that a good answer to your question?

Katrina Miller Parrish
It sounds like is not necessarily unanimous. It is not really a vote. It is a consensus and without objection sort of thing.

Sarah DeSilvey
Yes, very much so.

Katrina Miller Parrish
Got it.

Sarah DeSilvey
Al, Ike, Wendy, Seth, am I missing anything there?

Al Taylor
I think Katrina's summary was perfect.

Draft USCDI v5 Data Elements Recommendations & Level 2 Data Elements Recommendations (00:06:47)

Sarah DeSilvey

Okay, fantastic. I think we are over in column ... the column where the recommendations are. I think it is Column M. Most of the columns, most of the elements have a final recommendation and process in Column M. What I would like to do today is move as many as possible to done-done. I have personal concerns on some of them I put in there, but we have plenty of time to get to them. Has everyone read sufficient the final recommendation for the Emergency Department note, sufficient to have a consensus at this time? Any concerns in the ecosystem on that one? Are we good to move it forward? Katrina, yes?

Katrina Miller Parrish
So sorry. I did, and I want to say thank you to Ricky and Hans for all their work on developing the final recommendation. I highlighted "if possible" and "could be chosen" because I noticed that we really strayed from some level of requirement for an at minimum, or a shell, or something. I am really concerned this is going to lead us to not have a Logical Observation Identifiers Names and Codes (LOINC) code chosen or some appropriate code chosen. Maybe I am misreading that. I am wondering if Hans or Ricky could speak to this, and why it is stated this way. Thanks.

Sarah DeSilvey
The good thing is your comments relate across both this one and the surgical operative work because there is a theme there. Once we resolve this, we can move both forward. Hans?

Hans Buitendijk
I appreciate the comment. The intent was not to not have a LOINC code, but rather to allow for the word that was not highlighted, "distinct from", so that it would be possible to consider, not necessarily say you must, but you could consider the narrative notes could have a different LOINC code than the document that is typically more than a narrative note. That was the intent of the writing. That is why, if possible, it could have to be read in combination with "distinct from" if that helps identify it.

Katrina Miller Parrish
Yes, that explains it. I still think we need to add back in something that requires a code to be chosen, and then separately, distinct from the LOINC code that is used for other types of notes.

Ricky Bloomfield
This is Ricky. That makes sense, and I agree with both of you. One thing that we could say is remove the "if possible" and say "if appropriate".

Katrina Miller Parrish
Yes.

Ricky Bloomfield
Or we could say a LOINC code should be chosen, period. If possible, this LOINC code should be or could be distinct from the LOINC code used for the full structured emergency department document. Something like that just to make it ambiguous that a LOINC code should be chosen. Would that be okay?

Katrina Miller Parrish
Yes, with me.

Hans Buitendijk
Good.

Sarah DeSilvey
Can we edit that in real time just to see? Would someone mind going into Column M and doing it right now so we all can see?

Hans Buitendijk
Or do you want us to edit and then we come back and see whether it hit the spot either way?

Ricky Bloomfield
I can make that change right now.

Sarah DeSilvey
Just for the sake of putting it to bed. Steven?

Steve Lane
I am a little unclear about the purpose of the last part of the sentence here. About "could be chosen" as part of subsequent data modeling discussions. That is vague enough for me to not know what we are saying.

Sarah DeSilvey
As Ricky is typing, Hans can you help answer that one, so Ricky is not taking two at once?

Hans Buitendijk
Sure, but I am not sure whether Al had his hand up before me. He might give a similar answer. Do you want to have Al first?

Sarah DeSilvey
Okay. Al, are you going to give a similar answer?

Al Taylor
No. I will provide a little baseline context with respect to other USCDI data elements. Our pattern has been, and our intent is to continue with the pattern of setting a minimum LOINC code for certification to represent this. Not an exhaustive list, but to at least indicate that technology can represent emergency department note with a given minimum LOINC code. That is how we have done it before. That is how we phrase it as well. If the recommendation is to change that convention, or the recommendation is to change the one that we selected as a minimum code, then the recommendation ought to be shaped like that.

Ricky Bloomfield
I just updated this text if you want to take a look at it again. If this makes sense ...

Sarah DeSilvey
Hans, do you want to respond to Steven's comment, and then we can hopefully resolve these two recommendations?

Hans Buitendijk
Yes. I appreciate Al's comment beforehand. Before making the comment, the intent behind this was that when we get to modeling and Fast Healthcare Interoperability Resources (FHIR) or Consolidated Clinical Document Architecture (CCDA), etc., if the LOINC code is totally locked in and represents what would otherwise would be a document code that now has to be used for a narrative, it will be challenging to say if USCDI locks in on a code, let us say the one that it sees more clear in the next one that is around that is also used for a document type, then changing that for operative note and have a distinct one for narrative would be hard because now USCDI has locked it in completely.

It is not that we say there cannot or should not be a LOINC code. We want one, but there is not a strong notion yet that it, is the one that is being chosen the right one to be able to allow us to be more easily distinguish between narrative summary notes versus a full document. That is the challenge, and it is a little bit of a dilemma here. I understand what Al is saying. In principle, I am fully in agreement with it. We need to have that but locking it in already with USCDI and then finding out later that it actually needs to be adjusted is much harder. That is why.

Sarah DeSilvey
Understood. I am going to have a couple more comments on this. I just want to figure out action items to resolve these recommendations. Steven?

Steve Lane
Is the problem that LOINC itself does not differentiate a code for the full encounter document versus the narrative note section? Is that why you are hesitating?

Hans Buitendijk
Correct. There is in LOINC not a clear distinction. Sometimes there could be. Sometimes there is not. You mentioned that narrative paragraph or could be mental health, but that narrative note versus a full document that does all the structuring out of data as well, that distinction is not clearly always available in LOINC. That could be obtained by pursuing that when everybody believes that is the right thing to do. This is trying to give that flexibility to resolve that. In the end, we still have the LOINC code. We do not want to have no LOINC code. We are all in synch on that, but right now searching, querying, and distinguishing between the two is hard because LOINC codes have been chosen and actually serve a dual purpose.

Sarah DeSilvey
Are we feeling comfortable with the edits to the final recommendations as stated and understanding the flexibility of implementation that Hans and Ricky are mentioning, which relates to the conversation we had with these elements in the beginning of our work? Are we feeling good?

Hans Buitendijk
I think from an ONC perspective this provides that we agree with the minimum.

Sarah DeSilvey
Yes.

Hans Buitendijk

Hopefully, we can work on figuring this out sooner rather than later so that we can have the right solution. I am okay with it.

Steve Lane
I think this looks good.

Sarah DeSilvey
Is everyone feeling good about this? Nothing that although at different levels of maturity, the same type of comment is with the surgical operative note below. Al?

Al Taylor
I just wanted to point out that the way that it is phrased, the way that it is stated, the current data element uses this LOINC code as the minimum data code to be used. Just keep that in mind. The recommendation is to keep the same code that we selected for use as a minimum code, or recommendation to change it to something else. But what is listed in this recommendation is the one that we have already designated if you will.

Sarah DeSilvey
Yes, plus the flexibility that Hans was mentioning, correct? There is the detailing of the modeling discussions that were brought up in the original discussion as far as I understand. It is not a disagree. It is a yes-and.

Al Taylor
It has always been yes-and.

Sarah DeSilvey
Yes, exactly.

Al Taylor
The minimum part of it indicates that it is a yes-and.

Sarah DeSilvey
How are we doing? Are we good? Any concerns? All right, I am hearing no concerns. Are we okay applying the same principle and same recommendation model to surgical operative note as well?

Ricky Bloomfield
I updated that note with the same text, so it should match now.

Sarah DeSilvey
Awesome. I want to thank all the IS WG members who worked really hard on this. I know there were lots of conversations to resolve the elements and concerns raised in our initial meeting. Well done. Thank you so much, everybody. On to lot number, which is a fairly straightforward conversation, although it had immunization lot number, although it had sequelae into medications that we talked about later. If we can go to Column M here as well. It was a straightforward recommendation. Is there any need for further discussion? The pharmacy group was going to take out separate conversations regarding medications. Al?

Al Taylor
Sorry, just real briefly, and then I will stop talking. I do not think this has been discussed with the entire workgroup, but it is our intent to follow the pattern that we followed last year. That is to, 1). Make a blanket recommendation or a support statement for all of the data elements in Draft v.5.

Sarah DeSilvey
Okay

Al Taylor
Except for, or with the additional comments so the recommendation is stated for lot number, would be incorporated in the blanket statement at the beginning. We may not need a separate line-item recommendation unless there is some additional information that you want to add.

Sarah DeSilvey
Yes. For the purposes of our own tracking and seeing what we have covered, the final recommendation in M is helpful for us. I am going to reiterate what Al stated. If we are merely saying we agree we do not usually call it out in the transmittal letter. It is like a we-agree-with-the-elements, with the exceptions or additions as noted. Anything that is an exception or an addition is what we put in our transmittal letter. For our purposes, helpful. Thank you, Shelly, but just reiterating what Ali said, it likely will not make the text of the transmittal letter become it is included in the general agreement. Correct, Al? Is that what you were saying?

Al Taylor
Yes.

Sarah DeSilvey
Okay. Hans is asking for us to turn anything that is good to go in green in our past IS WG fashion, which helps us focus on things that remain. That is helpful. Moving on to test kit identifier, which in the recommendation there was universal agreement. There were some edits here. How are we feeling regarding the recommendation, participant identifier in Column M? Any concerns? Thank you to the IS WG members who worked on this.

Steve Lane
I have a question.

Sarah DeSilvey
Okay.

Steve Lane
How is this different than a we-agree statement? We have renamed it from test kit unique identifier. We gave it a different name, but we are still pointing to the item that was in Draft v.5, correct?

Hung Luu
Yes, that is correct.

Sarah DeSilvey
Hung is ready. Hung?

Hung Luu
Yes. This is basically the same recommendation as we had made in v.3 and v.4. The only difference is we removed the unique because there was concern that having the unique device identifier would lock us into thinking that we are requiring the device identifier and the production identifier right off the bat, which the current technology does not support the production of identifier, which would be an expiration date, a serial number, a lot number. This is to say that is eventually where we want to go. To start off, we are most interested in the device identifier, to be able to differentiate between different test kits, those that we know exactly how it was performed. Not so much the instant data of when does it expire, or when it is produced, but what exactly, which kit is it? Does that make sense, Steven?

Steve Lane
It does. I just want to make sure that our recommendation gets at the kernel of that because as I reread this through last time, it seemed like we were simply kind of reiterating why we agreed. This is fine if everyone agrees, but we could potentially shrink this down to what is the key difference of our recommendation from what was in Draft v.5.

Sarah DeSilvey
Hans, any thoughts on that?

Hans Buitendijk
Part of that comes back in the first bullet where it focuses on the reagent name and manufacturer, which it is a part of. I think that is more specific than I believe that is currently stated in the draft, the USCDI version 5 definition. It is not only to change the name to remove “unique” in that regard because it is less unique than a full Unique Device Identification (UDI), but that is to focus on the reagent name and manufacturer.

Sarah DeSilvey
Al, thoughts?

Al Taylor
Just going back. It sounds to me like the recommendation is to change the name and then explain why the name has changed. The last couple of comments have identified what those reasons are, but the recommendation should be clear that number one ... because it sounds like the workgroup wants to recommend the name be changed. Then, of course, there would be the why, as opposed to just we agree that this be added. I think the recommendation could be more actionable if it specifically says recommend change the name, and for these following reasons.

Sarah DeSilvey
It sounds like integrating Steven’s comments and Al’s comments because Al has to make that happen. Al is a good person to tell us whether they feel actionable. Hans, should we edit this in this moment, or how do you feel? Do you want to take this back and come back next week? What is your preference as the amazing lead and helper person on this element?

Hung Luu
I think we can change it right now.

Sarah DeSilvey
Okay, great. We are trying to clarify that we recommend a name change and why. That would address both Steven's questions about why it is not just an agree and Al's questions on how to make it actionable. What we will do is we will come back and let Hung work on it. We will keep on going down the list so we can keep moving along. Where are we? We are off to medication route, I believe, Column M. Is this just an agreement? Pooja?

Pooja Babbrah
Yes, it is. Now that we are giving that format, I think this is just an agree unless anyone else has any comments.

Sarah DeSilvey
Makes sense. Shelly?

Shelly Spiro
Totally agree with what Pooja is saying. This is a data element that is probably already included in some medications, but I think that calling it out is important. There are codifications for it, so I agree.

Sarah DeSilvey
Any concerns with just letting it be an agree? Hung, I am not going to put you on the spot. Just let us know when you are ready, and we will come back.

Hung Luu
Okay.

Sarah DeSilvey
Medication route, moving forward as agreed and will be part of our summary. Now onto the advanced directive observation element. Building off of the subject matter expert presentation from Maria Moen, very grateful for that. Really grateful for the extensive work of the Advance Directive (ADI) subgroup, Hans, Ricky, Shelly, and Mark. There is a lot to read here. If individuals have not read it yet, please do so now. Then we can have our discussion. Hans?

Hans Buitendijk
Maybe a quick clarification or suggestion, right now the term advanced directive information, issues for data class. Based on observation that I have had during the opportunity during HIMSS with Maria Moen and Lisa Nelson, the thought was to maybe adjust the recommendation for the name of the new data class to healthcare directive. The rationale is that one of the components of healthcare directives would be advanced directives, but also power of attorney, living will, and other aspects to it. It seems a little bit more encompassing than only using the title of the data class advanced directives which might be too narrow and set an expectation that is likely **[inaudible] [00:27:25]**. The suggestion, as you read it, to change advance directive information to healthcare directive information, or healthcare directive. Then it would nicely cover all of the examples that I used. Adjust the abbreviation accordingly.

Sarah DeSilvey
If you are ready for conversation, if any person needs a little help understanding ... I wrote this this morning. There are a couple of different areas, and we talked about this when we were together two weeks ago, of recommending use-case-specific data classes. We have the care plan recommendation and the healthcare directive recommendation as opposed to element-type classifications, which is currently what we have within USCDI. I am a little concerned that creates a precedent that it is not something that is necessarily normative for USCDI, and usually within the realm of the Interoperability Standards Advisory (ISA) or USCDI+. I would love a little bit of conversation. I 100% understand the elements themselves, but the naming of new data classes, and the creation of new use-case-specific data classes that leverage elements in other areas of USCDI is something I just need a little bit of understanding on. Katrina?

Katrina Miller Parrish
I think I am echoing what you are saying. I would be a little bit concerned when you are describing normative, that the industry would not understand the data class, as well as healthcare directive (HCD), as with advanced directive, just because it is a more known term. I would say we might want to work that into Level 2 and put that in development somewhat. If we really want a data class that matches all of the data elements that we are talking about here, I would match the terms because also I am thinking if we change this to healthcare directive, do we change all of these to HCD document observation, HCD unstructured documents, etc., to make the match? Obviously, that is a little bit of an exaggeration, but I would be very concerned about changing the data class name now with all of these elements.

Sarah DeSilvey
We have a couple of elements within the class. One is me raising the use case-specific data classes altogether, wondering on the precedent of that. Another is on naming conventions for that. This conversation is separate than my full-hearted approval of the elements themselves, which I am full-heartedly in favor of. Hans?

Hans Buitendijk
Thank you. I would like to react to both comments that were made. The first one, Sarah, that you raised a question about having use-case-specific data classes, whatever they are called. It is a bit of a tension between having very generic data classes that could be interpreted in many different ways, as we have seen in a number of different examples, or it is more specific and they can still be used in a variety of different use cases and areas, but they are a distinct kind of data that we are looking at. Generally, to make it actually easier, I would actually be arguing the opposite. Having more ... not too many, but more that are more specific, yields less ambiguity. You have to understand what actually the intent is of what we are trying to do, as opposed to take a little bit from this data class, take little bit from another data class, another one, and now you have a new construct that is in the context of a specific use case.

It is actually turning out to be much more challenging to make sure we all understand what scope is. I would be more in favor of having more, but not too many. It is always a tricky balance and in this particular case, I do not believe it leads to too many. Related to the other question, this is a proposal on what to name this particular one. It is a proposal for a new data class. It does not exist in USCDI v.5 yet. The intent is to better delineate and reduce ambiguity. The time to set a good name is actually right now rather than change it later. It is new, so we have the choice. When we look at the examples that are being used in the definition

and the proposal, in this text as well, examples include advanced directives, durable medical power of attorney, living will, and personal advanced care plan.

There are different varieties and different aspect of directives, but advanced directives has very particular meaning, as does living will, as does other ones that are not quite the same. If we use the title for the data place class directive, one of them is advanced directive, and then we have four or five, etc., other aspects as well that we are starting to address. We are looking at the availability of these ones, not just advanced directives. It is important to have a more appropriate name that covers everything in the data class, not just one.

Sarah DeSilvey
Thank you, Hans, for trying to do multiple. Shelly?

Shelly Spiro
Yes. I agree with Hans. I think that it is important because right now, what we have with advanced directives is a checkbox. Is their advanced directive done, or is it on file, yes or no? As we begin to make it more available with standards, as Hans has said, we are able to break it out into the different types of documents and relationship to advanced directives. Calling them out are important pieces as we move forward for certification. In terms of your other comment, Sarah, when we are talking about the use case aspect of it, I think it is important.

A good example is medications. We have medication class. We also have medication as a data element, and now we have just added route. Although some of those components can fit into other areas, we need to come up with a way of saying this data element fits into ... is a duplicate. It can fit into this data class, but it might also fit into another data class. It is important to go down that route eventually because when system vendors or programmers are using USCDI, or we are trying to identify USCDI, it is very helpful to have the class where that data element fits. That data element might fit in multiple data classes. USCDI.

Sarah DeSilvey
Thank you so much. Traci?

Traci Archibald
I agree with what Shelly was saying, that makes a lot of sense. I agree with Hans as well. I do not want to repeat them, but I agree this is a really important area to have that clarity.

Sarah DeSilvey
I am going to try to try to restate. I raised my personal concern regarding moving toward use-case-specific groupings of data elements. I am happy to be the minority on that because it sounds like my concern may not be in alignment with the rest of IS WG. I am just more accustomed to seeing these things in ISA and USCDI+. **[Inaudible] [00:35:42]** a minority concern too. One of the good things regarding this recommendation is it is actually the creation of something new, as opposed to the overwriting of an existing element. Of course, it is a critical concern. I am going to try to separate out the consensus finding here. We have the first element, they are all bolded because you all did such a lovely job. We have the recommendation for a new data class with a new updated name, arising from further conversations with

our Subject Matter Experts (SME) in real time at HIMSS. Any concerns? It sounds like we have a consensus on that.

Hans Buitendijk
Sarah, do you want me to go to change the name on this or not quite yet?

Sarah DeSilvey
Katrina had concerns on naming, I had concerns on the creation of class itself can. Both of us are comfortable being the minority concern on this even though everyone else feels content with that. I would agree with changing it if we are all in agreement. Ricky?

Ricky Bloomfield
The only comment I wanted to make was I do not recall the subject matter experts when they came, ever used the term healthcare directive. I am wondering if we can point to some precedent for this should be the term we use. I do not have a strong opinion either way. I just want to make sure this is something that is going to be clearly recognized by the broader community when we use it and will not cause confusion about what we are trying to do.

Sarah DeSilvey
Because of the newness of this one, it is one of those me recommendations, this would resolve Katrina's implementation concerns, right? It would be helpful to point at to something as evidence of the new naming convention. Do we have an ability to get that and then come back next week, and see an updated recommendation with the new naming conventions, and some kind of citation to support references and grounding?

Hans Buitendijk
Do you want to then make an adjustment by just marking it up, and then checking in with the presenters, particularly Maria Moen, and others, to say is this still aligning with your intent? Would that achieve that?

Sarah DeSilvey
Yes. The idea would be, right now we hear agreement for changing the name for right now. We will be reaching out to Maria and see if there is some type of citation we could use to support the change in naming, and she mentioned was a good idea at HIMSS. Anything to bring back to IS WG we can put in a hyperlink in the recommendation would be appreciated.

Steven Eichner
There is a note in chat about a potential alternate name, advanced care planning.

Sarah DeSilvey
It seems on multiple purposes and multiple intents, the naming of the class itself is what we are trying to figure out and trying to land. It was advanced directive depending, right? There was a proposal to change it, but we just want citation. If we look at the elements themselves, I hear no concerns on the elements. I think we have full agreement that they seem very, very critical. Do I hear a consensus from the IS WG on that, the elements as opposed to the class? Okay. That part being noted, yay. What we are trying to figure out is the name of the new class that is being recommended. We just need to figure out if we have evidence

to ground the change in name because if not, both the recommendation from Derek and the recommendation currently in there might be more normative for the ecosystem. Hans, does that sound like a good plan?

Hans Buitendijk
Yes. One comment on the elements. I believe the intent was that when we said ADI documentation observation, that it would not be advanced directives being present or not, but also has, based on some of the examples used, that it could indicate a living will present or not, power of attorney present or not. There are a couple of different ways in which that can then be done. Therefore, if we change the name from advanced directive information of the data class, that effectively for the attributes that ripples down because is not limited to only being able to be aware of advanced directives.

Sarah DeSilvey
That would relate to Katrina's question as far as I understand. How about this? We are going to see if we have evidence to change the naming conventions. Maybe the team that worked on this can think about this further. We are almost close to landing this because it is not like we are differing on agreement. We are just differing on wording. Does that seem fair?

Hans Buitendijk
I think so, yes. It is wording, not context.

Sarah DeSilvey
Yes. It is not ... thank you, Traci. We will come back next week and revisit this one to finalize it. Then if we can go back, we have a little bit of time, if we can go. Hung, thank you. We will go back for the test kit identifier element and see if we can land that one. Hung worked out it.

Hung Luu
The top recommendation is to change the name from test kit unique device identifier data equipment to test kit identifier. The second bullet point provides the rationale for it. Also, in the body of the last paragraph, it is to emphasize that we are encouraging the ONC to continue efforts to identify Medicaid infrastructure gaps that limit the capture and transmission of the production identifier.

Sarah DeSilvey
It reads much more clearly to me because it carries the weight of the why. Steven, your comments actually drove this. Are you feeling comfortable with this change?

Steve Lane
I like that. Thank you, Hung.

Sarah DeSilvey
Any concerns or comments on the final recommendation for test kit identifier as edited? Hung, thank you for your efforts, and for everyone who helped with this one. We are ready to call that one done, so hold on advanced directive. We have a little bit of time left for USCDI, maybe five elements. Level two elements, we are going to go to them on time. We can move to the next element after advanced director observation, which is the set of elements, even though sex parameter for clinical use is the first one, it is the set of

elements from the Gender Harmony Project and the SMEs there. Ricky, note those comments, I think that is some of what we need to consider, is renaming scope change. I hope we can figure that out between now and when we come back next week, and we can go from there.

I want to thank Mark for leading on this one and working so hard with the SMEs on the recommendations, the usage notes, and all the elements there. Is everyone comfortable? The notes on pronoun and preferred name are very brief. Are we feeling comfortable on the final recommendations for the set of three? Long time coming I want to note, on these ones. many years of work. Any concern on moving forward three Gender Harmony aligned elements with the comment on sex parameter for clinical use, which is a definition change, and usage note guidance, and recommendations aligning with some updates with HTI-1. No? Yay! Again, Mark thank you for working so hard on that one for many years.

Mark Savage
Thank you so much to the Gender Harmony project for their work in the past and their ongoing work in the future.

Sarah DeSilvey
That moves three to green. Orders was a tricky one because it was presented as part of the advanced directive element but also was thought about separately. It is a little tricky. We had some conversation on that. I believe where we fell was just going back to the original recommendation as presented by ONC and just being in an agreement, right? Then having the portable medical orders be rolled up into the advanced directive element, correct? Everyone is agreeing with me? So, this is just a move-along? Hi, Derek? I thought I heard Hans.

Derek De Young
Yes, Hans also left something on.

Sarah DeSilvey
I heard Hans voice, but I see Derek's hand. Derek?

Derek De Young
I know we did this for the one above, where we put the order for that specific thing into the data class. My worry is that this is a bit too broad or generic for being meaningful. There are a bunch of different orders the physician can place, whether it is for meds, specialty diagnostics. I threw some examples there in the box to the left, in Column L. But I almost think it would be more meaningful if we made specific orders for those orders that we all think of the most valuable in no specific data classes because each one of those orders will have different pieces of valuable information. Where if we just do one generic broad one, I think the usability of it on the receiving side could be lost, if we do not have meaningful data elements defined for each one of the types of orders. It is just more of a worry than a showstopper, but I think it would be beneficial if we actually separated these into specific almost orders or specific high-value domains.

Sarah DeSilvey
Thank you very much. We imagine this is the first necessary step, but I do note the implementation concerns. Hans?

Hans Buitendijk
I generally agree with Derek's concern. I wanted to add something further to it. Depending on the kind of order that we look at, there is already much more adoption, availability of data, other ones less so. If you go lab orders, medication orders, radiology orders, etc. there is already a lot that is available there.

If you go to a pulse, that do-not-resuscitate-type order, there is still a bit of work to be done to get to the right standard. Orders is a very generic data class. It has the risk that we have with some other ones that you need to combine orders with lab, laboratory or orders with medication, or orders with procedures, or whatever, in order to better understand what we are trying to achieve in scope at this point in time.

Having more clarity on what exactly it is we are trying to do would be helpful. If at the same point in time, it would be the absolute bare minimum now and then we can work through that and say you would like to have an order code like we have on the laboratory side, what seemingly is the lab test performs, not the lab test ordered, although it would be ordered as well, that might help at least the initial step to keep that focus.

The challenge is going to be when we take this as defined, as stated, just generally orders, it is going to be very hard to understand what do we need to include when we modify your score, what is the minimum data set required, what kind of orders, what kind of test, etc.? I am completely in sync with Derek there and would look at the ones we have more defined. The ones less defined, I would actually be very careful using them as examples, like a do not resuscitate. We start to get into pulse. There is still some. How do we best represent that? There is still some work to be done as well. This is a big mix that we have in this group that creates ambiguity.

Sarah DeSilvey
I am hearing a couple of things. I am hearing that either this is a yes-and, and the IS WG leads into specifying this further. Or am hearing that this is okay for now and then in next year's charge we further refine. I just want to hold space for that and hear what Shelly has to say, and then we can further discuss and figure out next steps. Shelly?

Shelly Spiro
Sarah, I agree with what you are saying. I think it is important that we have a way to codify the types of orders, as Hans is saying. I think that was in the Level 2, at least the view of the Level 2, not necessarily what we were just looking at. We were looking at advanced directive orders.

I think these types of orders, as was said before, medications, laboratory, there are types of orders that are important, and this goes back into what I had said earlier of duplicate elements under different classes. It is something I think would be important to look at overall by ONC as we move forward.

Sarah DeSilvey
Thank you, Shelly. Steven?

Steve Lane

Yes. Sarah, you said perhaps we either start with something vague, ambiguous, and impossible to implement and then come back and fix it next year, or we start with some specification of what the starting point is and then build on that year-by-year.

I think the concern with the first approach is history bears out USCDI v.5 might get named in rulemaking. We do not want to let anything into any version of USCDI that the industry really does not know how to act on. I would opt for the idea of specifying where this starts, the types of orders that will initially be expected and will come interoperable, and they are reportable. Then build on that over time.

Sarah DeSilvey
Then it includes but is not limited to ...

Steve Lane
Exactly.

Sarah DeSilvey
We are not trying to be exhaustive. I want to note that there was a concern in the chat. This would imply that we are moving for work on the final recommendation representing the suggestions for possible specific types of orders and then coming back next week. Hung?

Hung Luu
I was going to say that we have had electronic order entry for a while now. It is not like this is a novel concept that we are proposing. I do think it is necessary to include because we need to be able to capture what is in the Electronic Health Record (EHR), that data that is kind of chaotic and disorganized right now.

I want to make sure first that it makes it to version v.5. We operate on electronic orders. It is an element that needs to be represented in something that **[inaudible] [00:52:27]**. The second part is that it does make sense to specify on how to represent things. The most key part is that it can be done. I just do not want it to not be included.

Sarah DeSilvey
Thank you so much, Hung. What I hear is pretty much agreement on how important this is, and long time coming, again, but a desire to have IS WG do what it does, which is a thoughtful yes-and. If folks can identify themselves to help create that final rack, which is a yes-and, then convene and represent this next week that would be helpful. Is anybody willing to do the yes-and final rec drafting? Raise hands or we'll hunt. Al, what are your thoughts?

Al Taylor
I wanted to be clear that I am not volunteering to write this.

Sarah DeSilvey
I know you are not.

Al Taylor

Just for the record. Just a suggestion and I think it was Ricky who said we have been doing orders for a long time. I want to acknowledge that that is one of the reasons why orders as a generic data element have been added to USCDI because ONC certification requires that computerized provider order entry (CPOE) occur. A suggestion or an idea for how to frame this, to Hans's point about it being too generic to be meaningful, a suggestion and something to consider, is to recommend that there be some sort of minimum number of orders, a minimum number of types of orders that must be represented, including the three that are included in CPOE, which is medication, diagnostic imaging I think, and one other. I am sorry. I do not remember.

Steve Lane
I assume it is labs, right?

Al Taylor
Yes, labs, medication, and ...

Steve Lane
Imaging.

Sarah DeSilvey
Yes.

Al Taylor
Those are the three that are already required that certified health IT would be able to perform that function. Not the content but the function. There is no standard associated with the format of those orders, only that the function be supported. That is just an idea about how maybe to frame it. If it is about a suggestion about more specific ones, those might be good candidates.

Sarah DeSilvey
It also gives us something to point to create boundaries around the includes-but-not-limited-to. I see Steven, Rochelle, and then maybe Katrina. Are you volunteering to help with the draft, or do you have a point?

Katrina Miller Parrish
I certainly can help, but I do not think I am the best. Some of the vendor folks might be better than me. I was going the other direction. I was going to say could we have a generic agreement and not get too specific? I am concerned we might twist ourselves into pretzels trying to get too specific here. That would be my suggestion, but yes, I am happy to help in continuing the final recommendation.

Sarah DeSilvey
Great. Noted, Katrina. It looks like Hans and Derek are offering to help as well. So, thank you so much, everybody. I do want to switch to Level 2 elements on time. I want to acknowledge that Pooja wants us to hold on medication until she is back. We have plenty of time to do that. We have gotten through a lot, so we will pick up. The two elements that are coming back next week for USCDI v.5 advance directives and orders, and then drop in to author, starting with author next week. Then we are going to move to Level 2 elements. I do not think we necessarily need to go back to the slide deck to do that. We can just move on to Level 2 if we go down. I am just making sure. We are still in draft in the v.5.

Steve Lane
Sarah, did we skip over interpreter needed?

Sarah DeSilvey
Yes. What I am doing is, in order to not forget again, not get to our Level 2 friends. I am trying to follow the agenda. At 11:00 switch us, I think it was 11:00 when we were going to switch to the Level 2 elements. Then we can come back and start with v.5 again next week. I hope that is okay. I just do not want to move. I do not want to miss the Level 2 elements again.

Al Taylor
That is fine. I just wanted to clarify. That makes sense.

Sarah DeSilvey
I believe before we went into Level 2 our friends, and I am sorry to put you on the spot. I hope it is okay, Alex and Traci, there was some thought on CMS, general comments on Level 2 elements that would be helpful from a CMS and CDC combined perspective. Is that true? Again, I do not want to put anybody on the spot, but any thoughts from CMS in general on Level 2 elements of note?

Alex Mugge
I probably need to check with Joel. Traci, I do not know if you have anything.

Traci Archibald
Yes. We have several. I was just going to try to see if it fit into the discussion, and then I can add anything at the end if that works.

Sarah DeSilvey
Great, okay. We will start with Level 2 at the top then and move along to the CMS elements if we can, which I am sure we will be able to get to. We had care plan that was a Level 2 element. We talked about this extensively over the course of the last couple of meetings. The recommendation is, I think if the scroll over, I believe, Mark, you put it in the Column L because not wanting to populate Column M yet until there was some agreement on how to go forward. Is that correct?

Mark Savage
That is right. I was not sure. Since we had not even discussed it, it seemed like maybe it was a little presumptuous to put it in M, which I did not want to do.

Sarah DeSilvey
If everyone, you can see it is on the bottom of Column L. This is where I raised my question on the naming of the data class that is basic specific. In this instance, it is a renaming of an existing data class. And so, I think it is a little bit of a different concern than adding a new use-case-specific data class. This would be the renaming of the assessment and plan data class. Again, I have no question on the elements as offered. But I have a little bit of concern with the renaming of an existing data class unless it is through ... I am the minority again. I do not have to worry. Any thoughts on the care plan recommendation as noted in Column

L? That looks like Katrina and Mark. Again, I feel like it is a little different this time because it is a renaming and not a novel data class, which has less risk. Rochelle?

Rochelle Prosser
You did call on me, right, Sarah?

Sarah DeSilvey
I did, yes.

Rochelle Prosser
There are recent updates in reimbursement modeling for support workers and ophthalmology care navigation, which I look to care plan and the establishment of a plan of care, either by the physician or the nurse or whatever that support worker is. It is now, as we move forward in how we reimagine how data elements are used, is causing some confusion there if we remain with the old standard of patient summary and patient end plan because we are changing the element names actually in CMS levels. I do not know CMS wants to concur with that. I kind of agree with the last statement, to say-

Sarah DeSilvey
It looks like Traci did comment from a CMS perspective, so she might have agreed with me. Again, there are different conversations here. It looks like what I see here to be the general consent and agreement on the recommendation for a care plan element and the text as noted with a definition usage note and examples. But then there is the other conversation regarding the data class.

Mark Savage
Which is under the additional recommendations at the bottom.

Sarah DeSilvey
Correct, correct. Any further comments on the data class renaming?

Traci Archibald
Nope, I concur.

Sarah DeSilvey
You concur with the naming or you concur with –

Traci Archibald
Renaming

Sarah DeSilvey
Okay. I am a cautious hold-out again. I hear Katrina echoing. Katrina, do you want to speak?

Katrina Miller Parrish
Yes. I am still working through this, especially my family physician brain, and just trying to figure out if there we are sort of merging too many aspects of a care plan, and we should not be doing that. I am not sure I am completely understanding or have an opinion. But when I see assessments and plan of treatment

merging into care plan summary, that one makes me a little worried. I am also not sure about the overlap of patient summary and plan, into care plan. But on that one, I would probably defer, and there are if care plan seems to be a better, more generic statement that really covers that combined care plan. The second one is concerning me, the care plan summary. I do not know the difference on that one. So, I am a little more concerned about the second bullet. I will just say it that way.

Sarah DeSilvey
Mark?

Mark Savage
I do not know if this helps to that question, but the idea was that, and this came over from USCDI, from the workgroup's work on USCDI v.4, the thought that a narrative description remained helpful. So, you see in the additional recommendation, it does say that it would remain a narrative. It seems within that sense of that care plan summary was a more descriptive term than assessment and plan of treatment. Just providing a little background if that is helpful to this conversation.

Sarah DeSilvey
Thank you. I am just going to echo Katrina from a family medicine perspective, what AMP means to me is not necessarily contained in what care plan summary evokes. So, Rochelle?

Rochelle Prosser
Looking a little bit deeper and hearing Katrina's concerns from a nursing perspective that assessment, planning, intervention (API) is actually separate from the plan of care. You do the API first, assessment, planning, intervention, to determine what your care plan will be based on the sum of the results. In that case, I do agree that it should be separate, but if you leave it as a category saying we want the API plus we want the second part, I am just a little concerned as to what we are trying to achieve with the second bullet. Are we trying to include the social determinants of health assessment and all that that incorporates under the pulse assessment or are we trying to incorporate two things that really should not be incorporated?

Sarah DeSilvey
I am just going to hold. Again, there are two conversations here. One is the agreement on the element as suggested, and one is the data class, right?

Rochelle Prosser
Correct.

Sarah DeSilvey
Yes, and so I am going to keep on trying to hold. Traci?

Traci Archibald
We recommend that we rename both the data class and the data element to care plan, and recommend adding care plan information assessment, health conerns, goals, interventions, and outcome evaluation to the care plan. It is a structured package of core data elements that serve as the blueprint shared by all the

care team members to guide the patient's care. We want to make sure that all of those pieces are clearly identified. I will stop there.

Sarah DeSilvey
Rochelle?

Rochelle Prosser
So, Traci, I am not trying to throw a bomb in the mix here but just understanding. You are renaming it to three things, and two would be a separate class, or what are you exactly proposing? I just want some security for myself, where you are saying the renaming, or what you are proposing if you do not mind.

Traci Archibald
That the data class and the data element are renamed to care plan because patient summary is already included in the notes data class, where there is discharge summary notes, history, and physical progress note, etc. So, we wanted to keep this in its own separate class.

Sarah DeSilvey
Again, it could be considered an evolution because as we add more and more discrete note types, the need for a separate data class for assessment and planning mg not be necessary anymore. I think that is probably what we might be witnessing. Hans?

Hans Buitendijk
I really the removal of the ambiguity by exchanging the names, adjusting it, definitions, and provide that. From that perspective, support this direction. There is a part that I want to see whether it can be further clarified as well. As we were talking in a prior discussion around ADI, which is about what the patient wants and who they are giving consent to make decisions for them, otherwise it is a living will, etc. At times, we have discussed that as a kind of a plan as well. If we are going to keep them as separate data classes, which I think can be very helpful, then it seems that the ADI or whatever we want to call it is much more from the patient's perspective what they like and prefer and intend.

This is more in combination with the healthcare advisor what we actually are going to plan with the care team that includes the patient and otherwise. In a definition, that distinction could probably be made more clear that this is really the healthcare delivery, the actual one that we agreed to move forward, which may or may not to some extent be able to accommodate the elements that are described in the ADI. ADI would be input too this plan, but it would not be a type of plan. If we can make that more clear so that we then are not going to drift in one of the potential scope between the two, that one is going to assume anything because **[inaudible] [01:08:43]** elements of the other one. They are related but they are different. That would be greatly helpful to understand what is the purpose and the scope of this plan.

Sarah DeSilvey
Thank you, Hans. That is good that this work is going to happen in tandem with the AI element. I am going to hold space for it. I think what we are going to need to do is take these thoughts and work on the recommendations, and maybe move that now to Column M, so we can see it uniquely. If the individuals who are offering such commentary can help in reframing that recommendation before next week that would be great. I want to propose that maybe, and I know it sounds like I am taking a different tack, but if there is

a new data class for care plan, that might alleviate some of the concerns about overwriting the existing assessment and plan one. If we are moving forward with the use-case-specific classes in order to assist implementors, the idea of creating a new one might be better received than overwriting an existing one. But I am just going to say that outlook and maybe that will not be the final recommendation. Mark, any final thoughts? I think we definitely need to take this one, work on a recommendation, and come back next week.

Mark Savage
No. I will save. My thoughts are not necessary at this point.

Sarah DeSilvey
Okay. So, if folks can, who, again, sorry to put anybody on the spot, but if our friends from CMS would be willing to help again because we really lean on your expertise and guidance in cracking that final recommendation. That would be lovely. We really want to make sure that we center your expertise in this.

Traci Archibald
Absolutely.

Sarah DeSilvey
Then we will come back next week. Any other volunteers? Mark, thank you so much for taking lead on this.

Mark Savage
Yes, happy to, and will continue to do that.

Sarah DeSilvey
Thank you so much, so much, yes. It looks like Traci is willing to help work on that, to maybe integrate some of the concerns.

Mark Savage
Great.

Sarah DeSilvey
Thank you, Katrina. You have Dale helping as well. You have lots of people. Thank you so much. All right, so then if we could move on to some of the other competitive elements in order to get to public comment in about 10 minutes. Next one, I believe, was health literacy. My apologies on this. Dayo and I were going to connect to HIMSS. We did not get a chance to do that. We will go over to the recommendation. I put on in the in there. Do you want to briefly speak to the element as you suggested, and raise from Level 2? I put in the recommendation that I mentioned two weeks ago. We have not fully discussed this one, so discussion at this time. Then Dayo, if you want to speak to this.

Dayo
Sure. Actually, it is Dayo. The A is silent.

Sarah DeSilvey
Okay.

Kikelomo Oshunkentan
For me, it is important to pull this back into this discussion because health literacy is another barrier to care. It is a Social Driver of Health (SDOH). It is acknowledged and needs to be addressed, specifically from a clinical standpoint, as well as an IT/technical standpoint because the information that you provide for the patient and that you and your team build for that patient, is based on their level of health literacy. For us, I think it is important to pull this back to the forefront to address it so that we can make sure that we are addressing all the needs of that individual patient to better assess them and better treat them so that our interventions are effective. I understand that it was brought up prior. I am not sure. I was part of this workgroup last year. But I do not understand why it fell through. I am happy to hear what previous members have to say about this, but that is the perspective that I was taking with regards to this. Thank you.

Sarah DeSilvey
Thank you so much. Mark?

Mark Savage
As I understand it, in summary we're saying health literacy is already a part of USCDI. It is actually a part of USCDI v.2, will be in the regulations with v.3. It is not that anything fell through. It is not that it is unimportant. It is very important. It is that it is already there. We want to appreciate that. That is my understanding.

Sarah DeSilvey
Correct. I did try to make, again, this is where I am going to take off my IS WG co-chair hate and put on my Gravity terminology director hat, and take ownership for ensuring that when, in future versions of USCDI, Gravity, updates and adds comment to the element so that we can make sure that the domains that Gravity have addressed prior are very clearly represented in the content of the USCDI. That is what I note here, is that the intention of Gravity and ONC is to keep that USCDI element as updated as possible and ensure that any domains that Gravity has addressed have pages in ISA to assist implementors. Does that seem to represent the intent? It is not that it was not addressed or not thought important. Just that it was, it is, contained within the existing SDOH screening assessments, diagnoses, goal statements, and interventions approach of the gravity project.

Traci Archibald
That is helpful. Thank you.

Sarah DeSilvey
Great. Any questions or thoughts on the recommendation, which really is an action item for Gravity to make sure that we update these elements accordingly so implementors are aware? Great. I think we can go down to the next element, which was just, I think it is an agreement. Here we go, over, this was the Level 2 element update and time, specimen, and I do not but there was even a recommendation. We have not talked about it. It was thought to be a universal agreement. Any conversation on this one? I want to make sure Level 2 elements get their just due, and the conversation advised WG appropriately. So, I hear Traci. I just want to make sure I understand what people are agreeing to. Are we agreeing with the recommendation from IS WG to advance specimen date and time to USCDI v.5 from Level 2?

Traci Archibald

Yes.

Sarah DeSilvey
Any other thoughts? I hear no other thoughts or concerns, which is great. That means if somebody could take the lead on drafting up a recommendation for us to review next week, that would be great. Katrina, do you want to take the lead on that?

Katrina Miller Parrish
Oh yes, I will do that one. I started it. I will just match the numbers.

Sarah DeSilvey
Wonderful. Moving on, is Aaron on to represent? I do not see Aaron on to represent the elements that he raised. I feel like we definitely want to make sure we are talking about them though, so I am going to not delay, and then understanding this is the first time we talked about these elements. We will have to revisit them next week once we have finalized those last USCDI v.5 elements. There was a recommendation to raise substance food from Level 2 to USCDI v.5. Al, you have a comment from ONC I imagine.

Al Taylor
I do. I just wanted to just like to highlight that an existing USCDI data element substance, non-medication, calls out both food and environmental allergens as in scope. If the recommendation is to separate out those two allergen classes or categories into separate data elements, I think the recommendation should reflect the rationale for separating them rather than including them together. We do feel like substance food is a component of substance, non-medication.

Sarah DeSilvey
Katrina?

Katrina Miller Parrish
Yes, that was my point. I am concerned about creating subclasses under subclasses. Then how do we define food, which I know probably we have a definition, but I am not sure we do. I would be against moving forward with this one if that is the right terminology, or very concerned about it.

Sarah DeSilvey
That is perfectly fine terminology. Shelly?

Shelly Spiro
Yes, I am struggling with this one. We do, and we are looking at drug interactions. You have drug-drug. The aspect of having good and how it is codified, mostly in LOINC and allergy and environmental, which latex probably is the biggest one. They are put into buckets, but to keep it in buckets, Al, as non-medication and medication, I think it is okay. I think it would be better if we further classified it as suggested in food, and then adding environmental. If it is at a later time if we cannot get it in now. Separating out those data elements could be useful as we begin to classify that, especially for interactions that are occurring in relationship to allergies. They come from different sources within compendiums also and codifying it. I am in favor of still further classifying them under allergy and intolerance as different data elements. But I am in agreement with whatever they decide to do. It is not something I am going to fall on my sword for.

Sarah DeSilvey
It sounds like this one definitely needs some further conversation. Any other further thoughts? We will move to public comment on time in two minutes, and then come back next week resolving those last USCDI v.5 elements, including the ones we sent back into the hopper. Are there any further comments on substance food? I hear some concerns. I hear some agreement. No? Everyone has spent all their words earlier on in the meeting. I definitely am not hearing that we are ready to go forward because I hear enough concern that we need to keep on working on it. Is that fair to say? Okay, so it is still in the hopper. I am going to state that at 11:24 we are going to try to move to public comment on time. We did a lot of really good work today. ONC friends, ready to move to public comment. Thank you so much, team.

Public Comment (01:21:30)

Wendy Noboa
Okay, thank you. We would like to open the meeting now for public comment. If you are on Zoom and you would like to make a comment, please use the hand raise function located on the Zoom toolbar at the bottom of your screen. Or if you are on the phone only, press *9 to raise your hand. Once called upon press *6 to mute or unmute your line. We will pause for a moment here to see if any members of the public would like to make a comment. Okay, it does not seem that there are any public comments, so I will go ahead and turn it back over to the co-chairs, Sarah and Ike. Go right ahead.

Sarah DeSilvey
Ike, do you want to close us out?

Steven Eichner
Sure. Thank you all for helping us work through **[inaudible] [01:22:32]**. We got a little more work to do, and then we will finalize our comments and transmit a letter to the HITAC for subsequent submission to ONC. We will see you all next week. Continue to make comments on the worksheet. We will get this stuff done. Anything to add, Sarah?

Sarah DeSilvey
Just that I see Mark's hand, but I want you to note that with our timeline because of the need to get a draft version of the transmittal letter to HITAC ahead of the April 11th meeting, the April 9th meeting is only if needed because we have to get the transmittal letter to HITAC ahead of that meeting. We are going to really try to finalize our recs in the next two meetings so that we can get that transmittal letter in time without revisions. Mark, maybe I answered your question.

Mark Savage
You did, thanks.

Sarah DeSilvey
Okay. Thank you so much, again, hopefully, we will see more final recommendations bloom, and we are doing okay. We are getting there.

Mark Savage
May a thousand recommendations bloom.

Sarah DeSilvey
April showers bring May recommendations. Thank you so much, friends, and someone else you next week.

Steven Eichner
Bye.

Adjourn (01:23:54)

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

QUESTIONS AND COMMENTS RECEIVED VIA ZOOM WEBINAR CHAT
Sarah DeSilvey: So good to see many of you at HIMSS last week! Such a busy time. But there were many ISWG hellos.

Rochelle Prosser: I am good

Rochelle Prosser: Agreed Hans

Rochelle Prosser: Great compromise

Steven Lane: Agree with differential identifying the narrative clinician note and the full encounter document.

Katrina Miller Parrish: Just added "At Minimum" if it fits well, @Ricky

Ricky Bloomfield: That works, thanks! I updated it for the other note type as well.

Katrina Miller Parrish: @Ricky - Great! Thanks!

Rochelle Prosser: Ketih +1

Katrina Miller Parrish: Yes. thx

Rochelle Prosser: Yes, Thank - you

Rochelle Prosser: Yes

Katrina Miller Parrish: Maybe we could add in the agreement with the ONC recommendation in the final

Traci Archibald: agree

Sarah DeSilvey: yes hans!

Pooja Babbrah: I'm in support of moving this one forward without a line item recommendation

Rochelle Prosser: Pooja +1

Katrina Miller Parrish: Thanks - then I won't further edit the agreement.

Steven Lane: Agree with use of the term “Health Care Directive”.

Traci Archibald: could we say Health Care Advanced Directive

Pooja Babbrah: +1 Traci

Steven Eichner: +1 Hans

Pooja Babbrah: Good clarification, Hans. Thank you.

Mark Savage: Agree with a more inclusive name like Healthcare Directives for the data class.

Steven Lane: Agree with Mark’s suggestion to add “S” at the end of the title for the data class.

Katrina Miller Parrish: I can be minority concern too

Shelly Spiro: @StevenL I agree with adding “S” at the end of the title

Katrina Miller Parrish: Agreed!

Derek De Young: ANother term used by the community for this is "Advance Care Planning", but I am open to either.

Derek De Young: https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-advance-directives-health-care

Mark Savage: Personally, think "Advance Care Planning" is more confusing.

Katrina Miller Parrish: Yes

Traci Archibald: yes

Kikelomo Oshunkentan: Agree - the element is impt to keep

Shelly Spiro: @Mark +1

Rochelle Prosser: I think the word "Health" should be added if we are going to be distinctive. I could be overruled.

Traci Archibald: How about Healthcare Advance Directive and Planning

Rochelle Prosser: Tracy +1

Rochelle Prosser: Happy to work with you on it Hans

Ricky Bloomfield: My only concern is that we may be inadvertently broadening the scope of this by renaming to Healthcare Directives, which may make it harder to model and implement without further effort, thus slowing down implementation of the items we've already discussed re: ADIs. But if we can point to something publicly that makes it clear that Healthcare Directives is the best and most recognizable term for this, that would be fine. Just don't want to make a last minute change that we haven't been able to discuss in as much detail.

Rochelle Prosser: Appreciate you concern Ricky. Happy to talk this through

Katrina Miller Parrish: +1 @Ricky, part of my concern.

Traci Archibald: Agree

Katrina Miller Parrish: Agree

Rochelle Prosser: Agree

Steven Lane: Totally agree with Derek. This is a big complex area. Additional specificity would be helpful to support implementation.

Rochelle Prosser: I think the intent was to salvage the Directive Order wherever it resided to include visability for EMT's as there is a necessity for viewing the original DNR.

Traci Archibald: +1 Hans

Steven Lane: Agree with Hans: Start with labs, imaging, meds - the things for which patients are most likely to "shop" to identify a vendor that best meets their needs - cost, convenience, linguistic, etc..

Katrina Miller Parrish: Agree yes and, good to start with the container for all orders.

Rochelle Prosser: Agree Hans on your prospective. Can we drill down later with refinment in future versions?

Rochelle Prosser: Concer HOward

Traci Archibald: Recommend updating the data element description to explain the Orders data element includes the details of each order, not simply a list of orders that provides no additional information.

Rochelle Prosser: "Includes but not limited to" is language I would like to see in the draft.

Howard Capon: Agree with Traci. An Order Data Element would mean sending the contents of each order - not a list of orders, which cannot be acted on by all providers.

Rochelle Prosser: Happy to help

Steven Lane: I can also help with the drafting.

Derek De Young: I can help as well!

Pooja Babbrah: I apologize all - I have to drop early today. In case we get to level 2 elements, hoping we can hold the medication one until next week so I can be part of that conversation!

Sarah DeSilvey: ok, pooja!

Hans Buitendijk: I can help too.

Katrina Miller Parrish: Agree @Sarah

Traci Archibald: agree

Kikelomo Oshunkentan: I am in the minority as I do not agree with the renaming.

Katrina Miller Parrish: Thanks!

Kikelomo Oshunkentan: @Sarah +1

Mark Savage: Recommendation is about renaming, not a revision of the underlying data element.

Katrina Miller Parrish: Thanks @Rochelle - agree with your continued assessment!

Shelly Spiro: @Traci +1

Rochelle Prosser: I think Assessment still need to be separate as a process to make a decion on plan of action.

Rochelle Prosser: +1 Hans

Rochelle Prosser: Yes Sarah

Katrina Miller Parrish: @ Traci - Could you add the CMS rec in this cell?

Kikelomo Oshunkentan: Agreed

Rochelle Prosser: Thank - you Traci

Katrina Miller Parrish: I will too

Kikelomo Oshunkentan: Happy to help as well

Rochelle Prosser: Only if it will not be used within an algorhythm to isolate or harm

Rochelle Prosser: QQ - How will this information be used to identify or target patient classifications?

Rochelle Prosser: Under use of Risk stratification I have concerns.

Traci Archibald: agree

Katrina Miller Parrish: Yes please

Rochelle Prosser: I agree

Shelly Spiro: I agree

Rochelle Prosser: I Agree!!

Rochelle Prosser: +1 Al

Sarah DeSilvey: we will move to public comment at 11:25

Sarah DeSilvey: et

Rochelle Prosser: So then adding a Data type?

Katrina Miller Parrish: How is a supplement categorized?

Rochelle Prosser: Sarah would we add Data Class?

Rochelle Prosser: Katrina +1

Shelly Spiro: @Katrina from a pharmacist perspective supplements are considered medications

QUESTIONS AND COMMENTS RECEIVED VIA EMAIL

No comments were received via email.

RESOURCES

IS WG Webpage
IS WG - March 19, 2024, Meeting Webpage

Tanscript reviewed and approved by Wendy Noboa, HITAC DFO, on 3/27/24.