The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) US CORE DATA FOR INTEROPERABILITY TASK FORCE 2021 MEETING

February 9, 2021, 10:30 a.m. – 12:00 p.m. ET

VIRTUAL

Speakers

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

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

Operator
All lines are now bridged.

Michael Berry
Great, thank you very much. Good morning, everybody. I am Mike Berry with ONC, and welcome to our USCDI task force No. 2. We are going to get started with roll call, so when I call out your name, if you could indicate your presence, that would be great, and then we will get started afterwards. I will start with our co-chairs, Steven Lane and Terry O'Malley.

Steven Lane
This is Steven. I am here.

Terrence O'Malley
This is Terry. I am here. Hello.

Michael Berry
Ricky Bloomfield?

Ricky Bloomfield
Good morning. I am here.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Hello, this is Hans.

Michael Berry
Leslie Kelly Hall?

Leslie Kelly Hall
Here, thank you.

Michael Berry
Jim Jirjis?

Jim Jirjis
Present.

Michael Berry
Ken Kawamoto?

Ken Kawamoto

Good morning.

Michael Berry
Leslie Lenert? Clem McDonald? Aaron Miri? Brett Oliver?

Brett Oliver
Good morning.

Michael Berry
Mark Savage?

Mark Savage
Good morning. Here.

Michael Berry
Michelle Schreiber?

Michelle Schreiber
Good morning. Here.

Michael Berry
Sasha TerMaat?

Sasha TerMaat
Good morning.

Michael Berry
Andy Truscott? Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
Dan Vreeman?

Daniel Vreeman
Good morning. I am here.

Michael Berry
And, Denise Webb? Is there anyone that did not hear their name?

Leslie Lenert
This is Les Lenert. I could not tell if I was on mute.

Michael Berry

Thank you. All right, I will turn it over to our co-chairs, Steven Lane and Terry O'Malley. Thank you.

Steven Lane
Thank you so much, Mike. I do want to point out – as you went through the roster, which is actually on the next slide – maybe you can just drop down to that for a moment – you did not call Valerie Grey because we heard from her just recently that she is not going to have time to participate with us, so since she will be removed from the roster, I just wanted to call that out. She had conflicting issues she had to deal with. And, we did hear earlier that Aaron Miri dropped in and then had to leave, so we will proceed. Let us see. On the next slide, we review our task force charge. Terry, did you want to take this? I cannot remember.

Terrence O'Malley
I think this is all yours, but it does not matter.

Review of Reformatted Task Force Charges (00:03:04)

Steven Lane
Okay, that is fine. I will go ahead. You will notice that we have reformatted this ever so slightly. We have added numbers and letters instead of just the bullets that were on the earlier version, and we feel that this will make it easier for us to find our way around the document and the charges that we have. So, we will be referring to Charges 1, 2, and 3 and Subcharges A, B, and C under 1 and 2. The other thing that we want to call out is that there was a slight change in the wording, and Al or Mike, clarify for me – I think this is under –

Al Taylor
It was Charge No. 3. We changed the phrase "areas of prioritization" to "priorities" to allow a little bit more flexibility in how the task force approaches Charge 3.

Steven Lane
Right. And, this was meant to accommodate the task force's desire to potentially develop a set of guiding principles when we take up Charge 3 after April, so, rather than specifically charges with developing guiding principles, we just changed the wording in such a way that we felt that it gave us that latitude. Does anyone have any questions about that? Good. I really want to acknowledge the flexibility of the ONC, as shown here, in supporting us in our early work. All right. So, let us just pop back up to Slide 2 – the agenda – just so that we have a clear set of marching orders here for our time together. We have managed the first two here. Terry, I think you are going to talk about the out-of-scope issues – or I can, either way – then we are going to focus on what we are now calling Tasks 1a and 1b, and we will close up with public comment as usual. Any questions or comments about the agenda for today? All right, very good. Then, let us pop down to Slide 5, which regards out-of-scope tasks. Terry, do you want to take this?

Out of Scope Tasks – Level 1/Comment Elements (00:05:42)

Terrence O'Malley
Sure. So, this is a really short one. Steven is going to talk to us about what is in scope, and I will talk briefly about what we are not going to do. So, it is pretty clear that what ONC wants us not to do is to get into the weeds on Level 1 and comment-level data elements because, in a sense, they are still being adjudicated,

and they are part of ongoing communication between ONC and the submitters to properly level these comments.

And so, I think if we were to wade into that process, we would only muddy the water rather than make ONC's task easier, and I think we will see what a monumental task it is because although we will not wade in and put our votes in about where the proper level is for these data elements, we are ultimately going to take a look at them as part of our work of prioritizing – of assessing how the process itself overall is going, how the priorities are being made, what the principles are for merging and splitting data elements, and basically, what the work flow is for ONC. So, we will take a look at these elements, but that is going to be later on in our process. In the meantime, what we will be doing instead is focusing on Tasks 1a and 1b, which is our charge for today. Any questions on what we are not going to do with this?

Mark Savage
This is Mark. It is not a question, but just a comment, if that is okay.

Terrence O'Malley
Sure.

Mark Savage
So, I recognize that this is the scope that is being defined for us. I wish we were looking at Level 1 and able to provide comments as a part of what we are submitting for April 15th. I have been looking at the USCDI. Like all of you, there are a lot of things that I wish were in that are not. Some of them in Level 1, like the primary care provider, are things that people really need to have. I would take a broader view and not look at what is classified as Level 1 among submitters, but instead take a strategic view and ask what we need now, and at least have some level of conversation about whether we think there are elements that should be a part of USCDI V.2 going forward without taking those off the table at the beginning. Thanks.

Steven Lane
Mark, thank you for those comments. I think I will just add that we are relying on ONC to have done the technical analysis of the individual elements early on, and some of us were involved in the first two rounds of the USCDI task force, but it was made very clear that we really cannot bring things forward to USCDI until they have been used, tested, exchanged, et cetera, so those sort of technical feasibility issues are not left to us to evaluate or adjudicate. ONC did that work in determining the level for each of the proposed data classes and elements. We obviously could quibble with their assessments, but I think the place to do that is in the comments on the web page. I think if we disagree individually or as organizations with the leveling, we can submit those comments there, but we just do not have time, unfortunately, within our task force to address those here. I think we are going to have enough to do as it is. Again, I am not defending that, but just trying to clarify that I think that is what led to our scope.

Terrence O'Malley
Yeah, Mark, we are going to find that there are hundreds of data elements that are in comments in Level 1 that we will wish were in USCDI, and the fact of the matter is that USCDI is never going to be big enough to hold everything that we want to put in it, but we share your pain, and I think we will have lots of opportunities to discuss how we might tweak some of the data elements, how we might – well, we will get

into a whole bunch of things, so stay tuned, and thanks for your comment. Steven, do you want to get us started for our cards?

Tasks 1a and 1b (00:11:00)

Steven Lane
Sure. Let us go back to Slide 6 now, which, again, is a reminder of what was in USCDI Version 1, which are those things that have stars on them, and what is now included in USCDI Version 2. So, our first task – Task 1a – was to look at data classes and elements from USCDI Version 1, including applicable standards version updates, and we talked about the proposed standards version updates last time. If we pop forward to Slide 8, we can be reminded of that and those changes, and a number of you individually weighed in with your general sense that this was appropriate and that the right standards were being advanced to the right levels. Did anyone have anything else that they wanted to add regarding that aspect of Task 1a, "Standards versions," that this group should contemplate while we are meeting, or do we feel that this is fine and that we should just check that box as completed?

Hans Buitendijk
Steven, this is Hans Buitendijk. I think the part – and, maybe you said it, but I did not quite catch this. From a vocabulary perspective, I think that is correct. In terms of other standards that are applicable that are named or maybe needed in USCDI V.2, I think that is where there might still be further discussion where it gets to syntax or otherwise to express the data that is being contemplated, but from a vocabulary perspective, I would agree.

Steven Lane
Yeah, and Hans, you did share that last time, and I thought to say – and, I will say it now – should we change this slide to say "Updated applicable vocabulary standards versions" because that is really what it is focusing on?

Hans Buitendijk
That would be very helpful to avoid any confusion.

Steven Lane
ONC, would you be comfortable with that, or should we just jot that down to go into our report to HITAC?

Al Taylor
We could clarify that. The use of that term "applicable standards" is what was used in the Version 1 standard. If we look at each individual data element and data class, there is a column referencing the applicable standard, and it is called "applicable standard." If it improves the clarity of what we mean by "applicable standard" by adding "applicable vocabulary standard," I think that would be something we could consider, along with **[inaudible] [00:14:00]** clarity for the standard document.

Steven Lane
And then, Hans, looking back at Version 1 and now going forward to Version 2, do you feel there is a need to include other standards? You mentioned syntax in particular.

Hans Buitendijk

I think as we are looking at the Version 2 draft in particular – what is being proposed and not – when we talked last time about if the proposals are building on standards that are already in place as part of certification, to what extent they can require some additional development or not and trying to balance that, then at that point in time, I think we are going to be looking at FHIR and CCDA in particular and see whether that is sufficiently in place to enable USCDI Version 2 to then be operational as is or that additional development would be needed to enable that. I think that is the part where those are other standards that are referenced effectively through certification and USCDI as well as the standards that support the ability to access and exchange that information, so I think that is the area where we will have to look at some point in time and ask if they are sufficient, if we need a little bit extra, and if the extra that we need is acceptable to then have to become part of SVAP as well to make it happen.

Steven Lane
Great, thank you.

Leslie Kelly Hall
Steven, this is Leslie.

Steven Lane
Yes, Les – sorry –

Leslie Kelly Hall
I have a comment – oh.

Steven Lane
I am trying to manage the hand-raising at the same time as everything else, so hold that thought. Dan Vreeman, who is only with us for about another six minutes, had a comment, so I am going to let him go first.

Daniel Vreeman
Thanks. My comment was just that I believe this reflects the reality today quite well and I am totally happy with it. I will note that the world keeps evolving, and so, by the time USCDI is finalized in July, I would expect that at least some of these vocabularies could also be updated – LOINC typically has a new version come out in June, for example. And, whether the group wanted to make a comment about that provision, meaning asking when we should set the marker for a current version as of X date and whether we want that in our consideration to be a finalization publication date or today as we discuss this right now.

Steven Lane
That is a good point, Dan, and I think we will need to discuss that with ONC, whether there will be some even newer standards that we could point to before they publish this later this year. Dan, again, I know your time is short, but you did forward us some key documents that included specific comments related to existing data elements and classes in Version 1, so if we can go back up Slide 7, again, part of our Charge 1a is looking at the data class elements in Version 1 and providing any comments on that. So, Leslie, I've got you in the queue in my head even though you took your hand down. Dan, do you want to take a moment and provide your comments verbally regarding Version 1 data elements?

Daniel Vreeman
Sure. Thanks, Steven. I am in the process of submitting them formally for the record to the site, but two things stood out to me. One is the existing data class and data elements around assessment and plan of treatment. My sense from the industry is that these are quite vaguely specified, and part – there is no applicable standard named, and the definition provided does not help too much, so without an anchoring to something more precise, I think commenters are left wondering whether this is a substantive plan of treatment meant to be, for example, only the A&P sections of a clinical note, an activity – for example, assessing their readiness to return to work or support – a diagnosis, a functional impairment, a condition, a scale, or is it, in effect, a whole plan of care or something altogether different. I am just giving examples of different interpretations, noting that the FHIR US Core replication or equivalent of this is a profile on the plan-of-care resource. So, without further clarification, I feel that it might frankly be worth removing this from the listing. That was one point.

The second was – and, I believe Clem may have some discussion on this later – regarding the moved elements for laboratory report narrative and pathology report narrative. In particular, there is some confusion about that laboratory report narrative data element, how it relates to lab tests that are reported as text as opposed to quantitative things versus comments or the interpretation field of an observation, or the whole diagnostic report, which has some elements of narrative inside of it. I feel like these are important clarifications to make as it sits now within the context of that data class, which has specific codes for the observation and a separate data element representing the results. So, thanks for the opportunity to briefly summarize those two points.

Steven Lane
Yeah, thank you very much, Dan. Dan made a key point at the beginning, which is that he is preparing his comments to submit through the website, and Dan also has a comment about some of the newer recommended data elements that he is going to be submitting there also. I think you all heard – or, some of you were also the recipient of some outreach that Terry, Andy Truscott, and I made to stakeholders to gain early input that we felt would be helpful to inform the work of our task force, and then we learned afterward that we cannot simply post these to a page or forward them to you for your consideration because everything that we considered here within the FACA task force needs to be part of the public record, so the means by which you all can share your individual comments or other organizations – including the public – can share their comments are really by voicing them here in our meetings and making them part of the public record, as Dan just did, or as the public has the chance to do during the public comment period at the end, or posting that feedback to the website either as text or attachments. So, we invite all of you, and we have invited everyone who provided input that they wanted to get to this task force with instructions to go back to the website and submit them there. So, I just want to make sure everyone is clear on that.

So, back to Task 1a, we are looking at data classes and elements from USCDI Version 1 that perhaps need to be clarified, modified, or deleted, as Dan suggested, and Leslie Kelly Hall, you had your hand up earlier. Are you still interested in speaking?

Leslie Kelly Hall
I am. It would be really helpful to see by class or maybe a spreadsheet or table that says, “Here are the things that are in USCDI that do not have standards – have gaps in standards – and here are the things that we are considering in future versions that do have standards” so that we can see where we should be

putting our emphasis. For instance, as a payer, it was difficult – I could not see anything for patient goals or anything in standards for that, but it could be something we would want to monitor and work toward, so it would be helpful to see those kinds of gaps.

Steven Lane
Yeah, and I will just say I think you are right, Leslie. That information is available on the website, and the navigation required to drill down and see what has what standards and look at the details can be a little burdensome. I have found that the "back" button works pretty well as opposed to clicking up above to get to other pages, but you are right, and we have talked to the ONC team about making some extracts of the individual items that we can have, perhaps in PDF format, including some of that detailed data that is on the site so that one can review it, perhaps in PDF as opposed to by navigating the site, but I think your point about which elements have standards associated is a key point.

Leslie Kelly Hall
And, the reason I am suggesting that we put this here as another slide is that it is an oversight responsibility as we consider due diligence – not just an information item, but something that says how we are moving along things that have standards and things that do not have standards.

Steven Lane
Terry, did you want to jump in?

Terrence O'Malley
Yeah. I can hold my comments for a little while. Leslie, I think you are onto a good point, and that basically is separating this oversight function from what the next steps are, which is actually to drill down on some of the data elements themselves. So, before I or anyone else jumps in, are there any other folks with broad comments on Leslie's level at this point? I think these are working.

Mark Savage
This is Mark. I will just jump in and say what I said in the chat, which is that when ONC came out with the drafting in 2018, it acknowledged that almost all already had some degree of technical standards, so I think it is an important question as to what that degree is, but I think it emphasizes Leslie's point, that it is good to have a sense of where we are. I hope we can get that sooner rather than later.

Steven Lane
So, we have hands raised from Leslie Lenert and Clem McDonald.

Leslie Lenert
I have a really newbie question. What does it mean when it is blank like that, as Leslie, Mark, and others were pointing out – when there is a category, but no standard or anything listed underneath? Is this something that we are going to get to eventually, or is it free text? What does it mean?

Steven Lane
I think that is a question for ONC.

Al Taylor

I was waiting for a pause in the action. When there is no applicable standard, one of two things are likely to be the cause of that. One is there may not be a consensus about which standard or list of standards to use. In other cases, there may be some disagreement in the terminology vocabulary binding between consolidated CDA and FHIR US Core, and when there are those misalignments or they are different, if we were to have an applicable standard, that would impose a higher bar compared to those other ones, and it would almost be a breaking change where you could not conform to USCDI and US Core at the same time, or any other combination.

Leslie Lenert
So, if it is blank, it means you just have not decided yet?

Al Taylor
I would not say that. I would say that where there are clearly identifiable applicable standards that everybody is used to and everybody uses, we will generally put that in there, but when those things are not the case, then we have not specified it in USCDI.

Leslie Lenert
So, is the job of the committee, then, to make recommendations on how to fill in the blanks, or is it just that we support you when you decide to fill it in? I am not trying to be sarcastic, I am just trying to – if somebody was trying to implement this, which will start happening very quickly, it seems like a pretty significant gap not to have any direction for this.

Steven Lane
Les, I would suggest that our Task 1a certainly could be interpreted to include the recommendation or specification of standards where they are lacking. Would you agree, Al?

Al Taylor
Yes. I think that is certainly in scope, and we will take that information. Maybe things have changed over the last year and it has become clearer what are the most appropriate applicable standards that everyone has to conform to. We will certainly take that note.

Steven Lane
And again, all of the members of the task force are also individuals, so you are welcome to bring those suggestions here to us for potential inclusion in our recommendations back to HITAC in the April timeframe and/or submit them yourself as comments on the website. I will just follow the comment that Les made, which is I assume that the absence of a specified or applicable standard does not in any way decrease the requirement for actors to access, exchange, and use the data, correct? You are still required to do it, you just presumably need to figure out on your own how you are going to do that.

Al Taylor
Right. That is correct, and the same sort of requirement to exchange a concept or a data element happens in the exchange standards as well. It may not be specified what terminology binding applies to a particular section or entry in CCDA or a resource or attribute in FHIR.

Steven Lane

Clem, do you have a comment? Oh, Les, go ahead.

Leslie Lenert
I just mean we have to – go ahead, Clem. Sorry.

Clement McDonald
It is in the chat, but I wanted to clarify the question that came up. We already have a solution to the next versions that are coming out. ONC has already explicitly said – and, it is in the chat from others – that if a new version comes out, people are allowed to use it. They do not have to wait for "mother may I" and another committee meeting.

Steven Lane
Well, I do not think that is complete, Clem, because they need to be specified as part of the standards version advancement process, the SVAP, before one can use the new version in place of the older version.

Clement McDonald
Well, I disagree. We ought to talk to ONC. The other way is not workable. I thought this was stated from the ONC folks at a previous meeting.

Al Taylor
Clem, that is correct. So, individual vocabulary versions can be used in systems. However, if a product was to update to USCDI Version 2, they would have to update all of the versions of all of the vocabulary standards that are specified as opposed to, say, maybe only updating versions every year, but if versions come out every two years, every six months, or every quarter, like some of them do, then I guess you could pick individual standards to update on any given time, but if you updated to USCDI V.2, you would have to update all eight or nine standards at once.

Clement McDonald
Thank you.

Steven Lane
Thanks for that clarification. That is great. Okay, Hans?

Hans Buitendijk
Yes. One question that comes up is what standards we are looking for, and I think here, we need to be careful or considerate about the distinction between standards and implementation guidance. There may be the ability for the standards to handle the data that is being proposed or considered, but perhaps there is not sufficient implementation guidance by way of – if we use FHIR as an example, the FHIR standard might be able to accommodate it, but US Core might not have full guidance on it yet, or other guidance to make sure that this standard is used consistently and appropriately so that we can scale it easily and everybody will be close enough to pick it up. So, we have to be cautious that when we stay "standards," are we just saying, say, FHIR R4, or are we also thinking of US Core, SDOH implementation guide, or another implementation guide that really achieves that level of consistency that we are looking for before we can scale it to a level where everybody will do it more or less the same?

Steven Lane
Hans, I would think that those would be appropriate comments to place at the individual data class or element level where you felt that that was lacking.

Hans Buitendijk
Correct.

Steven Lane
And, I just wanted to clarify something – and, it raises the point about using the term "applicable vocabulary standards" versus "applicable standards" – with respect to USCDI data elements coming either from Versions 1 or 2, we are not talking about the implementation in US Core or in CCDA of that data element, we are talking about how to represent the data element itself. So, "applicable standard" refers to the vocabulary standard to represent the data element, not the implementation part of it. That is part of the overall developmental burden that was addressed. Does that make that clearer?

Hans Buitendijk
The question that I would have then is if we only look at the vocabulary standards as the applicable standards in the context of USCDI and data is being proposed for inclusion, and the other standards that enable the actual exchange of it in a predictable format and placement, then are we achieving what we want to achieve? Because at the same point in time, certainly in certification, the notion is that to implement USCDI, one should use FHIR and CCDA to do that, so if we already know as part of defining USCDI Version 2 or any version that in that space, the vocabulary might be well defined, but the other standards are not sufficiently defined to achieve some of the objectives, is that one of the principles we should use on whether to include or recommend it for USCDI Version 2 or any other version? So, it is a little bit of a challenge as to what is the criterion base on which something is considered ready to go into USCDI.

Steven Lane
I think my short answer would be if we – our decision to put it in the USCDI Version 2 draft weighed the potential implementation burdens or developmental burdens for exchange standards such as US Core and CCDA, so that was part of the consideration for adding it to the list of USCDI. The question that we have for this particular task is did we pick the right vocabulary standard? That is the scope of the question.

Hans Buitendijk
Okay.

Steven Lane
All right. We remain on Task 1a, related to data elements and classes from USCDI Version 1. Does anyone have any other comments that they want to bring forward?

Terrence O'Malley
Steven, let me chime in here. This is an area that has the potential to blow up widely because USCDI V.1 had a lot of partially completed data classes, but one of the issues we need to wrestle with as a task force is going to be that part of our job may be to go back and flesh out some of those partially clarified data classes in V.1. As an example – and, this will warm Clem's heart – the issue of laboratory tests – how broad is our concept of "laboratory"? Does that include procedures? Does it include reports from EKGs,

spirometry, nerve conduction, LPs, and all the things that have text? That then makes it almost a procedure note. Can we broaden "laboratory" to include a bunch of other elements that are not traditionally thought of as labs? That would be one question I would throw out there.

Clement McDonald
Well, since you mentioned my name… **[Inaudible] [00:38:07]** thought of this last time, so I can…

Terrence O'Malley
I am sorry, Clem. I missed the last part.

Clement McDonald
I think they have a very similar function, and a lot of them are reported in the same kind of structure in V.2 and FHIR, so it would be nice to have it cover all those, but I think there is a clarity in the clinical world of what a laboratory test is, and it does not include EKGs.

Terrence O'Malley
Okay, I think that is a gray area.

Clement McDonald
Well, we are both internists, but I would bet if you voted on it, internists would not think of EKGs as a lab test. They can go to the lab.

Terrence O'Malley
So, where would we want them to go?

Clement McDonald
Well, we have to have them. I am for that. They are in the similar format – if you are saying we should use the same strategy for all the tests, I am for it.

Terrence O'Malley
I am not sure we could get away with it, but that is the point. Do we take some of the concepts that were in V.1 and stretch them nearer to beyond recognition, or do we need to come up with new data classes? I guess part of that is an ONC response, but the practical matter is how do we get more into USCDI, and if we take that approach, what does that do to the burden of implementation, which I think is one of the heavily weighted criteria that ONC uses?

Steven Lane
Terry, this reminds me of other areas where ONC has published FAQs to clarify their sub-regulatory guidance, if you will, and I think your point about EKGs as a subset of cardiopulmonary testing in general – which you can imagine all sorts of other kinds of testing – audiograms, fetal monitor strips, you name it – does ONC intend for that to be included in laboratory test results and the result narrative, or, as you say, are we awaiting future data classes to capture cardiovascular testing specifying the individual elements capturing pulmonary testing, you name it? Al, could you comment on that?

Al Taylor

I wanted to reference what the current definition of "laboratory test" is, and I do not have it memorized. The ability to capture a group of concepts, be it all of the procedure-type things that you just mentioned – cardiovascular procedures, any other sorts of procedures you can imagine – that could be a gap in USCDI where the definitions of either "laboratory" or "laboratory test" are not broad enough to incorporate that, so we cannot require that everybody be able to capture all those other tests, but the short answer is that may actually be a gap in either USCDI Version 1 or 2. If it is appropriate to capture it under "laboratory data," then it could be done, but it may not be.

Steven Lane
So, perhaps that is an area that our task force can address in our report to HITAC, which typically would then be accepted by HITAC as the report back to ONC. We need to start a list of these things that are going to end up in our report.

Terrence O'Malley
Steven, along the same lines as taking a prior V.1 item and expanding it out in ways that were discussed last year, one would be in the area of provenance, where we really limited it to the author organization and author timestamp, but there are a whole bunch of other concepts that we played with under provenance that certainly have value. One is making sure that "author" includes a designation for patient-generated data as an example. If we are identifying authors, then one of the author types should be the patient – the individual, perhaps even their immediate caregivers – to expand out how we identify "author."

Steven Lane
Terry, just to be clear, under "provenance" on Level 2, "author" is specified as a Level 2 item that was not brought forward into draft Version 2. Similarly, when you look down at Level 1, "source" is specified under "provenance," and under "comment…" Oh, there are a whole bunch of additional data elements under "provenance" that were leveled as comments, so I think a lot of what you are pointing out – those stakeholders have submitted new data elements to go under "provenance," and again, one of them is in Level 2, one of them is in Level 1, and then there are about 10 of them at the comment level.

Terrence O'Malley
And then, there is sort of a general comment that could apply to almost any list that we could think of – allergies, meds, problems, goals – which would be who did it and what was the date of the last review? One of the real tremendous problems is maintaining all of these lists. What is the latest data? Who did it? Is this a problem from two years ago, or is this the current one? So, again, this is just a concept that we might want to wrestle with at some point, and I do not know whether that fits under "provenance" or somewhere else, but we will have many things to do.

Steven Lane
So, we have a number of hands raised. Les Lenert?

Leslie Lenert
I meant to put mine down, sorry.

Steven Lane
Okay. Leslie Kelly Hall? Oh, hers is down. Now we've got Michelle Schreiber.

Michelle Schreiber
Yes, hi, thank you. Good morning. Just to complicate this even further, it does seem to me that the underlying question is the philosophy of what is in USCDI, if this is ever meant to be the total repository of standardized data elements in the country or if there are going to be other areas that encompass standardized data elements. I will only add – and, a few of you guys have heard this from me – some of the concerns from CMS. So, we obviously have quality measures programs and elements in that that the country has to report, for the most part, and yet, of the 57 quality measures that we have that are electronic, only four of them are supported by the data elements of USCDI, and I think we agree that there are things that almost everybody would want – encounter disposition, encounter location, Medicare ID, patient's ID number, organization ID – that we think cross lots of areas that people would use as well as some other more specific categories. So, the question is how big do we think USCDI should be, how all-encompassing, and what do we do for things that are truly federal programs that need support? Thanks.

Steven Lane
Thank you, Michelle. I just want to note for the benefit of the task force as a whole that Michelle did reach out to us with some of these comments in greater detail, and we are planning a meeting between CMS and ONC to talk that through. I think it is a key question as to how much USCDI should expand and how quickly to meet the needs of various stakeholder groups, CMS obviously being a key one of those, and this is a decision that ONC will need to make as they finalize Version 2, but certainly, all of us have an opportunity to comment on it. Ricky?

Ricky Bloomfield
Thanks. Unfortunately, I have to drop off at 8:30, but I have a quick comment and question about – can you hear me? I am getting a note.

Steven Lane
Yes, I can hear you.

Ricky Bloomfield
I have a quick comment about the mechanics of feedback here. I heard earlier in the call that you mentioned that all feedback needs to be given publicly, which totally makes sense. The question is whether that feedback can only come during the audio portions of these calls, or if there will be a mechanism to provide feedback in written form in other ways, and trying to think about how some of us are more visual, and having a document of some sort that lists all of the elements of the USCDI along with the current standards as well as the comments from members of this group about this individual standard as a cohesive, consolidated document would be really helpful given that sometimes, these meetings are incredibly rich in terms of feedback, but it is hard to wrap my mind around everything that has happened without seeing it in front of me, so I am wondering if something like that is planned, whether it is meeting minute notes or some sort of collaborative document that is publicly available and accessible so that we can see all the feedback in one place.

Steven Lane
Thank you, Ricky. Again, that is very similar to feedback that we have already given to ONC, and they are considering how to provide that. Thanks to others for chiming in with support for this idea. Ricky, I think the

way you laid it out – the idea of a document for each data class and data element that includes its specifications from the website and all of the comments that have come. Obviously, comments can be coming in real time, so those would obviously need to be updated over time, but I think that would help us all to be able to dig deeper into those. Your point about documents to be displayed and discussed – I think that would probably be fine in the course of our meetings if somebody had a document that we could bring forward and display to the group as a whole. That would be a means by which it would be entered into the public record and could be posted to the ONC website for historical recordkeeping. Mike or Al, do you agree?

Michael Berry
Yup.

Al Taylor
Steven, the other point – and, to Ricky's as well – is that we are publishing meeting notes on HITAC. Mike, correct me if I am wrong, but I believe it is on the HITAC task force website, and we have first meeting notes that we are finishing right now that will be posted, so there is a bit of a lag. We will post meeting notes which include the typed comments as well as a summary of audio comments.

Steven Lane
Okay. The hands are down. Can we go to Slide 9? So, this is part of our Task 1a – oh no, actually, I think we are moving on to Task 1b, this is very exciting – where we are now starting to look not just at comments related to Version 1 and applicable standards, but are now looking at the new content that comes forward in V.2. So, the first piece of V.2 is this notion that the certain items have been reclassified. So, there are two – or, three, actually – clinical note types that are specified in V.1 that have now been moved over into these new data classes for diagnostic imaging and laboratory. To me, personally, that seemed fairly straightforward, but does anyone on the task force have any specific comments, concerns, or suggestions related to the reclassification of the clinical note data elements into these new categories?

Hans Buitendijk
Steven, this is Hans. I just raised my hand on this. The question is not whether the reclassification is generally a concern. I think it makes a lot of sense to have them in those areas in context, but that immediately raises the question – as an example, as you look inside diagnostic imaging, what is now the difference between the imaging narrative and the imaging report? How do we want to further look at that? Is it really the aspect of the report that needs to include a narrative component to it, or is it something separate? I think that is where we need to look at it a little bit further to see if yes, that is the right place for it to be, but are we creating a duplication or should we integrate that?

Steven Lane
In addition to raising the question, Hans, do you have any suggested answer?

Hans Buitendijk
The suggestion is to consider it more part of the report where there is a narrative component to that. That depends on the report. In the case of diagnostic imaging, it is a narrative plus other data, but in other cases, it might be more narrative or less, but it is part of a report where that is included. That will be the initial reaction to look at.

Steven Lane
Thank you. Is there anything else on the reclassification of the clinical note data elements?

Ricky Bloomfield
This is Ricky. My comment was very similar to Hans's. I completely agree here with this reclassification. I think that makes sense. But, similar to what Hans was saying previously, there is some inconsistency in what is now present here and what is in US Core, where in their clinical notes, US Core has guidance – the first five categories are consistent with the first five categories that are listed here on this slide, and then they have three additional categories which are three diagnostic report categories which systems shall support, and those are cardiology, pathology, and radiology, and you can certainly see some overlap with the pathology report here, but then, the cardiology and radiology – you could say that radiology is diagnostic imaging and pathology is laboratory reporting, but just make that explicit that these are referring to the same categories within US Core. I think that could be helpful just because the terminology is a little bit different, and then we can talk further on about the additional three note types that are referred to in US Core as part of the USCDI.

Steven Lane
I will just tell the team that I have lost my connection to Adobe Connect, and I do not seem to be able to reestablish it quickly, so, Terry, do you want to grab the baton and move forward since I cannot see raised hands or the slide?

Terrence O'Malley
Sure. So, I trust we are done with this slide.

Clement McDonald
No, we are not. I have my hand up. I would like to respond to the discussion of this narrative. I think the diagnostic imaging narrative should just be eliminating. It is very confusing. It says it is the interpretation, but it is more than an interpretation. What it really says is that it is a consultant's response to a diagnostic image. I am not sure what that is, so I would propose that we drop it, and the same with the other two narratives, or certainly clarify it a whole lot. If an independent consultant – not the radiologist – describes something, that is okay, but it should be spelled out.

Steven Lane
Clem, I am not sure I understand what you are saying about independent consultants. I think of the imaging narrative as the radiologist's report in text.

Clement McDonald
Well, there is another place where we have radiologist reports and imaging reports, so that is why it was confusing. As both of the earlier speakers said, we have a place for them and it is all spelled out, and this is something extra. I think what the definition says – if you get into the definition, it is a consultant related to an imaging report, and I think it is a mistake.

Steven Lane
Al, can you clarify?

Al Taylor
I think what Clem is referring to is the data element definition in the USCDI standard document itself. Is that right, Clem?

Clement McDonald
Yeah.

Al Taylor
We do have a data element definition which – currently, for imaging, the data element is called "imaging narrative" in USCDI Version 1, and it says "Contains the consultant specialist's interpretation of image data." I would welcome any suggestions to improving that data definition.

Clement McDonald
If it is – we ought to clarify that this is not the radiologist's report. I think that is certain because there is another place you have a whole class for that. So, there is a case that often happens where an orthopedist wants to look at the **[inaudible] [00:58:18]** report, that would fit, but then, we should explain it that way.

Al Taylor
And, this is the verification that we would like to have. One thing that I wanted to convey – and, I have done this in the standards doc and discussed it with the US Core group as well – the intent of having these three data elements in USCDI is to convey the desire to be able to capture narrative or free text elements of a report.

Clement McDonald
But, that is the standard radiologist's report. It is mostly all narrative.

Al Taylor
No, it is not. Some of it is standardized, including some of the technical specifications of the study, the patient, the provider, the ordering provider – those are structured elements of a report, and there are narrative or free text portions of a structured report where the whole purpose behind adding clinical notes is to be able to preserve the ability to capture and share free text information.

Clement McDonald
No, I am for it, but every single report I have seen in the last 20 years from radiology is just text. It is not coming across as a FHIR structure, as a V.2 structure – sometimes, they break them apart into sections, but it is – they are all narrative.

Steven Lane
Clem, I think what Al is saying is that this is not something different. I think this reference to "specialist consultant" is a reference to the radiologist who interprets the report, not some secondary review by a neurosurgeon or somebody else.

Clement McDonald

Then it duplicates the other section. It gives codes for all the diagnostic narrative – all the imaging reports. Something is wrong.

Steven Lane
One of the things that might help with this a little bit – I put the link from the clinical notes guidance to US Core in the chat here – they try to break this down a little bit and even provide a Venn diagram between how this could be implemented, and I think it is important to note that for the EHR vendors that have already implemented US Core, this is generally the guidance they have followed, and so, it is important to know that there are many systems today that already support this type of interaction based on guidance from US Core.

Clement McDonald
Well, there is another problem. You have one code for what are over 6,000 different diagnostic reports in radiology alone, and the other part of the proposal specifies that you can use all of them to distinguish the reports as they come across. So, something is broken. There is just a deep misunderstanding somewhere. What is going to happen is there will be no information in the report code if they all use a single code.

Steven Lane
So, Clem, just to clarify your question, if you can perhaps send us an email spelling out just what you think is duplicative – this with that – so that we can get that to the ONC team…

Clement McDonald
Well, could you just – I mean, I did. You got an email from me this morning. Could you just pull up the USCDI and show that there is another place that has imaging reports?

Steven Lane
Are you referring to the web page or the PDF documents?

Clement McDonald
The PDF documents.

Steven Lane
Okay. I do not think we can pull that up in a timely way here on the call. Are you talking about the Version 1 PDF document or the Version 2 PDF document?

Clement McDonald
Version 1 – well, I am not really sure… It is the new USCDI. I am still confused whether it is Version 1 or Version 2.

Steven Lane
It sounds like you are talking about the Version 2 PDF document – the 14-page document.

Clement McDonald
[Inaudible – crosstalk] [01:02:20] to deal with this meeting.

Steven Lane
Al, I think you understand what Clem is saying, that the diagnostic imaging report is listed under the new diagnostic imaging class, but there is also a diagnostic imaging narrative. There are actually two items here.

Al Taylor
Right, that is part of the reclassification. So, Clem, if I understand your question, if you are suggesting that the diagnostic imaging report and the diagnostic imaging narrative are duplicative, then that is definitely a valid comment.

Clement McDonald
That is what I am suggesting. And, worse than that, when you go **[inaudible] [01:03:12]** they are going to have a hell of a time reading them with some computer system, so…they are duplicative, and one of them is collapsed in a black hole into one single, infinitesimal point.

Al Taylor
We anticipated this particular piece of feedback about the duplication of diagnostic imaging report and narrative, and the same could possibly come up with the laboratory as well, and that is fine, and this is exactly the kind of feedback that we want and actually are already getting on that particular data element.

Clement McDonald
And, just one more point – at least in FHIR, where there is structure – sometimes – and, of course, in these kinds of reports, the amount of structure is very variable – there is also a place to put the whole narrative report in its entirety – the PDF, or whatever the heck you have got.

Steven Lane
Hans, you put a relevant comment in the chat. Do you want to give voice to that?

Hans Buitendijk
Yes. I think one of the reasons why clinical notes have been starting to come up is the challenge that we have run into over the years – it almost feels like decades – that the CCDA document started to get very big with lots of information in it, but not a good summary as to what it represents, and therefore, the balance between having narrative notes and structured data supporting information, if you will – we have had challenges with that, and this is an attempt – an effort – to right-size that so that where we talk documents like discharge summary, diagnostic report, or otherwise, that we strike a better balance between summary, narrative, and other data, and that CCDs in particular that have been very "bloated" – there still may be a need for that kind of a data set to be exchanged to just get data back and forth, but that there is a need to have better summaries, and this seems to all play into that.

Therefore, separating out notes and narrative from the data that support that narrative and that give the clinician that background on "This is what the event and visit was about, this is what the procedure was about, the highlights, and the details" – if we try to separate it out, we are going to effectively swing the pendulum in the other direction where we have narratives, but not the supporting information. So, I think we are trying to strike a balance, and therefore, the report seems to be the main focus that needs to have the right amount of narrative and the right amount of structured data and coded data in it to make it useful. And, separately, we have the opportunity to still send lots of data – coded or otherwise – to exchange that

because that is just to make sure that data sources are in sync. So, that is where my comment in the chat is coming from, and also, the rationale of why narratives should not be separated from the report, why diagnostic imaging narratives should be part of the diagnostic imaging report, because that is where we get the entire context.

Steven Lane
So, Hans, I think what you are saying is aligned with how I think of this, that the narrative is simply part of the report, that the report may include structured data elements as well as a text blob or more, which represents the narrative.

Hans Buitendijk
Correct.

Steven Lane
Is that a fair assessment, and Clem, does that jibe with what you are saying? These are not so much duplicative, but one subsumes the other.

Clement McDonald
Yeah, but then, I do not know that it needs an extra code. That is how FHIR is specified. You can always do that, and still, in terms of radiology, most of the reports you see are really just narratives.

Hans Buitendijk
And, that is okay. They can be more or less. It is the right amount that we are trying to aim for, and I think with CCDs in particular, the experience has been that that has not been enough, and it has been very big and bloated and a challenge to get insight into it.

Clement McDonald
I think Steve has it right, but then, the problem becomes if they are going to send this separate thing called "narrative" without a name on it except as a general report, and I would hope not, but I do not think it needs – I mean, it needs more explanation, then.

Steven Lane
Yeah, and I think perhaps it could be as simple as saying "diagnostic imaging order" under "diagnostic imaging." Actually, if you go up to Slide 6, you have the diagnostic imaging order, you have the diagnostic imaging report, which then includes diagnostic imaging narrative when applicable. I think the same is going to be true for laboratories, and we sort of did it there. Again, in "laboratory," we have values, results, laboratory report narrative, pathology report narrative – really, I think that is part of the report. It seems a little different in "laboratory" because there, I think we called out values and results separately. Some diagnostic imaging will have values results. I think about quantitative studies, mammograms, DEXAs, et cetera. There can be values results in the diagnostic imaging report separate from the narrative. Would that be a better way to classify it in V.2, to have values results and then separate that from narratives the way it is in "laboratory"?

Clement McDonald
I think it would be better to say that it is in the report.

Steven Lane
Leslie? Your hand is up.

Leslie Kelly Hall
My concern is if this narrative is separate in any way, can it cause other cascading problems or harm because there is no context for that narrative? So, generally, the narrative is a key component of the report, and my overall concern is if we feel documents are too large as a technical group, coming up with some artificial way to chop these up is not realistic in care, where the context and the narrative is so important. So, I do not think we are solving the right problem. If the documents are too large and we have not classified them, in a way, it is not about making them less important, but perhaps stronger vocabulary associated with it rather than splitting them up. I agree with Clem that the narrative has always been part of the report.

Steven Lane
Okay, good. Just a heads up – we are going to public comment in about 10 minutes. Let us jump back to Slide 9. Any other comments about the reclassification? I think that was a really helpful discussion, Clem, Hans, and Leslie, so we will work with ONC to figure out how best to capture that.

Clement McDonald
Well, if I may, in terms of imaging reports, a lot of people assume it is just radiology, and if it is, that should be asserted, but even colonoscopies often have images in the reports – pictures of the gut – so I think it would be useful to have some little phrase somewhere saying "including all clinical imaging studies" – retinal pictures, colonoscopies, cardiac echoes, et cetera – so that people understand that it covers the waterfront. That will help you a little, Terry. It will get you a little more sorted.

Steven Lane
But, I am a little worried that we are creating a bunch of separate categories that somewhat overlap and do not really add clarity, but on the other hand, if we mash them all together, then we lose the ability to distinguish among them. I think this is a bit of a conundrum.

Clement McDonald
Well, I was told at one of the earlier meetings that ONC intended for the imaging report not to be equivalent to the radiology report – any kind of report that had imaging included.

Steven Lane
Yeah, they certainly classified as diagnostic imaging, which, as you suggest, would improve the other images beyond those done in the radiology department.

Terrence O'Malley
Just a question – so, the difference between an imaging report and a laboratory data report…?

Clement McDonald
There is no specimen in the imaging report.

Steven Lane

But, as we said, some imaging reports clearly have multiple specific data elements. I think Sodexo was the example that I gave you. There is a lot of data in there, very similar to a lab test.

Clement McDonald
But, nothing which should contradict that, I do not think.

Terrence O'Malley
Or forbid that.

Steven Lane
Okay. If we can go to Slide 10, it is just a reminder that our task was to look at the data elements and classes from USCDI Version 1 and provide any comments, additions, clarifications, or modifications. Dan Vreeman had to leave us, but he actually recommended removing one of the elements from Version **[inaudible] [01:14:01]**, the assessment and plan of treatment. Did anybody have any thoughts about that? Is it a big deal to say we want to strike something from USCDI as opposed to adding something? Did anybody have any thoughts on that?

Clement McDonald
It is too bad he is not on the call. If that is just narrative, that is already written in those notes, and so, I guess that will not cause extra work, but if it is all structured and coded, that is not something that occurs, and that would be extra work for the clinical system.

Steven Lane
Well, what he said in his comments – and again, he is going to be posting this – is it was not clear what this was actually looking for. Was it the "assessment and plan" section of the narrative notes? Was it some specified element like a scale or a care plan? I think it is true that there is a need for more clarification of what ONC is looking for there. I would be curious from Sasha, Hans, or anybody representing a vendor to know if it is clear to you what that means when I say "assessment and plan of treatment"? Has your company determined how you are going to exchange that?

Sasha TerMaat
This is Sasha. I think the assessment and plan of treatment actually dates back to the CCDS, so this may be a long-term challenge. From my experience – and, I welcome Hans to chime in – folks have found ways to implement it, although I was sensitive to Dan's comment earlier that many of the things he mentioned could reasonably be considered part of an assessment and plan of treatment, and that is not likely to be consistent across systems today. So, do systems include something as the assessment and plan of treatment? I think we know certification has assured that they do. Are they all consistently including the same things in that category? Probably not.

Clement McDonald
But, if it is done only for human reading, it probably does not matter a whole lot.

Mark Savage
Steven, I have a hand raised if it is an appropriate time.

Steven Lane
Sorry, go ahead, Mark. I missed it.

Mark Savage
I would like to hear a little bit more about the details. I think that is a pretty important structural class and element from a variety of stakeholders' perspectives, including patients, and before deleting it, I would like to understand a little better what the problem is and look at whether the approach is to provide the structure and detail needed rather than deleting the class or element.

Steven Lane
I tend to agree with you, Mark. I think that could be our feedback as a task force. Do others have thoughts?

Hans Buitendijk
This is Hans. When you look at general use, I think perhaps the definition is not as clear as it could be, but when you look at US Core and CCDA – which is kind of where Sasha is going as well – there are data classes in there – care plans, goals, and others – that address aspects of that, and that's more on the "plan of treatment" side. The assessment side is where there are other capabilities out there as well. So, are we consistently doing it so that the same kind of data ends up in the same places using the right observations, activities, or otherwise in the respective standards? Clearly, we need to work on that, but I am not sure that it is a matter of removing this, improving the definition, or perhaps making a differentiation between plan of treatment versus assessment that assessment starts to overlap with other aspects. Where does that fit? I think it requires more work, but not necessarily a removal.

Steven Lane
Should we discuss this more next week beyond our agenda to nail this down?

Clement McDonald
Yes. But, an assessment plan is a traditional part of a physician's note or maybe a nurse's note, but it is what you say at the end, and historically, it is all narrative. It is really what you think it is. It is sort of a diagnosis, but not necessarily, and then a plan. That is not the same as structured care plans, which are often multidisciplinary, so it is tricky. We have to wrestle with it. I would be cautious of putting additional structure and putting a "click, click, click" on the backs of physicians.

Steven Lane
Yes, thank you, Clem. Mark, I wanted to take a moment and point out the fact that you posted a comment onto the website and included an attached document. This was a letter that you wrote to the ONC back in October. I wanted to just bring people's attention to that as a way to provide feedback to this group and to bring ideas into the public record for our discussion. Mark, did you want to take a moment to say something about that document, or should we just let people go find it and view it on their own?

Mark Savage
I will give a quick summary so people can decide whether they would like to. At UCSF, we asked internally what providers needed among the structured data elements of USCDI, and in general, they thought they needed a lot of it that is not even included in V.2, so that letter explains the criteria and rationalization that people use for why particular elements need to be brought in immediately or be moved up the queue. A

second piece of that later was to actually use COVID use cases – one where the patient had COVID and was treated at home and one where the patient had COVID and had to be brought into the hospital immediately – and use that to illustrate the importance of having structured data elements now. So, I think it is a good test case in the current environment for understanding how important our work is and providing at least one health system's way of thinking through how to decide about including elements. Thanks so much, Steven.

Steven Lane
Thank you, Mark. Okay, let us go on to Slide 12 and just point out that all the work we did today was really focused primarily on Task 1a, and we just started scratching the surface of Task 1b – actually, not even. We were really just looking at the reclassification. So, we are going to cut to public comments now, and then we will come back and talk about where we are going to go from here.

Public Comment (01:21:47)

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

Steven Lane
Nothing in the queue?

Operator
There are no comments at this time.

Steven Lane
Again, let me encourage members of the public who are here and listening not to be shy about providing verbal comments at the end. Personally, I wish there were enough comments that we needed to stop 10 or 15 minutes ahead to take them, but you are all also welcome to submit comments on the website. All right, let us go to Slide 16, which just talks about our upcoming meetings. We are basically going to continue to meet on a weekly basis. We proved to ourselves today that we can dig pretty deeply into these issues. Terry, you suggested coming back around to the discussion of assessment plan and treatment next time, and I think that would be helpful if someone is prepared to draft some suggested language clarifying that. I think if we just throw it open to more ideas, we could do a whole 90 minutes on that.

Is there anybody who would like to take a stab at suggesting – Mark, you said that is important, that we should not ditch it. Hans, you mentioned care plans and goals. I think those are called out separately on the USCDI site. I will just jump back and double-check that, but I think there is a general agreement that that element or data class from USCDI Version 1 is in need of some additional fleshing out. Would anyone like to take a stab at that? Hearing none, I am not sure – we can put that up as an item to come back to at the beginning of our meeting and see if anybody – again, "patient goals" is in there separately from "assessment plan of treatment," and maybe people might want to take some time drilling into each of those to see whether they think there could be valuable clarification made.

Clement McDonald
Steve, I do not think we will get – that is a huge space, and I think we could spend life in it, and I actually think it is probably what I have always seen as part of a physician or caregiver's note, so I do not know whether we can make progress on that. I would dedicate a lot of time to it.

Steven Lane
Well, again, Dan came at it from saying that it is just so unclear that it is redundant and we should move it, and Mark understandably said, "Whoa, whoa, whoa, this is important to a lot of people." So, again, if people could come with some sharp ideas that are formed and we can touch on those at the beginning of our next meeting, let us, and otherwise, let us plan to really turn our attention at our next meeting to Charge 1b, focusing on the new data classes and elements from USCDI Version 2, including applicable standards. I am sure many of you already dug into that part of your homework, but this will give you another week to dig further. I found that when I dug in there, there were some specific questions that I had that I personally put in as comments on the website, and I think if people want to do that, we can see what each other is thinking.

Mark Savage
I will jump in to say I do not think I am the best person to take the lead in drafting an assessment, but I am happy to collaborate with somebody who is perhaps more in the weeds about all of that.

[Crosstalk]

Clement McDonald
Steve, if we sent you something today, would that be something we could **[inaudible] [01:26:36]** in the next meeting?

Steven Lane
Yeah. If people want to submit some ideas, I think Terry and I can massage them into something that we can discuss.

Clement McDonald
I think you already got it from me. Maybe you did not.

Steven Lane
I do not know. I have not been watching my email during our meeting.

Clement McDonald
No, it was before the meeting.

Steven Lane
Okay, we can look back.

Clement McDonald
Let me know if you need it again.

Steven Lane
Okay. We are at time. I want to respect everybody's time and get to my next meeting. Thank you all for your participation. Any parting words for the good of the order?

Clement McDonald
You are a patient person.

Steven Lane
Thank you all so much. Bye-bye.

Terrence O'Malley
Thank you.

Leslie Kelly Hall
Bye.

Adjourn (01:27:24)