The Office of the National Coordinator for
Health Information Technology℠

Transcript

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

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

VIRTUAL

Speakers

Name	Organization	Role
Leslie Kelly Hall	**Engaging Patient Strategy**	**Co-Chair**
Steven Lane	**Sutter Health**	**Co-Chair**
Ricky Bloomfield	Apple	Member
Hans Buitendijk	Cerner	Member
Grace Cordovano	Enlightening Results	Member
Jim Jirjis	HCA Healthcare	Member
Ken Kawamoto	University of Utah Health	Member
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
Michelle Murray	Office of the National Coordinator for Health Information Technology	HITAC Back Up/ Support

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

Operator
All lines are now bridged.

Michael Berry
Great, thank you. Good morning, everybody. I am Mike Berry with ONC, and I would like to welcome you once again to the USCDI Task Force, our March 9th meeting. I think this is No. 6, maybe even No. 7. I have lost count, but we are moving ahead. I am going to open up the meeting today and call roll starting with our co-chairs. Steven Lane?

Steven Lane
I am here.

Michael Berry
Leslie Kelly Hall?

Steven Lane
We heard from Leslie that she was not going to be able to join us this morning because of a family issue.

Michael Berry
Okay. Ricky Bloomfield? Hans Buitendijk?

Hans Buitendijk
Present. Good morning.

Michael Berry
Grace Cordovano?

Grace Cordovano
Here.

Michael Berry
Jim Jirjis?

Jim Jirjis
Present.

Michael Berry
Ken Kawamoto? Les Lenert?

Leslie Lenert
I am here.

Michael Berry

Clem McDonald? Aaron Miri? Brett Oliver? Mark Savage?

Mark Savage
Good morning.

Michael Berry
Michelle Schreiber?

Michelle Schreiber
Good morning.

Michael Berry
Sasha TerMaat?

Sasha TerMaat
Good morning.

Michael Berry
Andrew Truscott?

Andrew Truscott
Good morning.

Michael Berry
Sheryl Turney? I know Dan Vreeman has a conflict today, so he will not be joining us. Denise Webb?

Denise Webb
I am present.

Michael Berry
Thank you, everybody, and I would like to turn it over to Steven. Take us away.

Past Meeting Notes (00:01:44)

Steven Lane
Thank you so much, and thank you, everyone, who has made the time to join us. I am sure we will be joined by a few other folks over time. This is our last meeting before our first presentation to the HITAC committee tomorrow morning, so we are excited to go over the materials that have been prepared for that meeting, and then try to get through as best as possible the comments that we have collected regarding, actually, Tasks 1A and B – I think there is a little typo here. If we get to Task 1C, that will be great, but I think my goal for tomorrow is to have 1A and B as tidied up as possible.

With regard to past meeting notes, those are being completed and posted to our website – to the HITAC website, that is. You can access them by going to the HITAC calendar and clicking on the meetings on the individual days. I will ask you, Mike, to provide an update on how we are doing on the task force's own website and when we anticipate that will be live. I know that has run into some snags along the way.

Michael Berry

I actually just got an update yesterday. I know they are diligently working on it, and I think Michelle Murray is on the call. She is following it closely. Can you give us a quick update, Michelle?

Michelle Murray

I am sorry, I only heard the last part.

Michael Berry

I was wondering if you could give a quick update on the webpage.

Michelle Murray

Oh. I am literally working on it right now. We ran into a glitch or two behind the scenes, but we are moving ahead to get something up very soon.

Review HITAC Update (00:03:29)

Steven Lane

Wonderful. We really appreciate that. I know these have been unusual times. Thank you to whoever just put us back on mute. It was a little noisy there for a bit. All right. So, we are going to go into our HITAC materials – basically, Al helped us to prepare materials based on discussions we have had to date, but of course, the material we cover today can be added to this verbally, and I am looking forward to doing that. So, I think in the slides, we have the high level of what we are planning on presenting tomorrow, and just to remind you all, this is a first pass of draft recommendations that we will then be bringing back to the HITAC in mid-April, more formally completing our recommendations related to Tasks 1A, B, and C. So, can we run through the slides here?

So, on Slide 3, this was the high-level summary, and the reason that we are going through this line by line is to make sure you all feel comfortable that we are representing our discussion, and any finer detail that you think is important that we include in the presentation, please let us know, and we will do that. So, we are first talking about Task 1A, which, of course, is to evaluate Version 1 data elements and vocabulary standards, and basically, we did that, we supported the recommended standards, we supported the reclassification of preclinical notes, but of course, there is more detail around that, which we get to later. We really wanted to make sure there was clarification of the scope of diagnostic imaging. There was a lot of discussion about what this includes or does not include with specific examples.

And then, some great work has been done on the assessment in the plan-of-care data class, and we will get to those details that Mark and others have prepared, but again, that will be part of our recommendation to HITAC – to have ONC provide greater clarification and perhaps even do some research into that. Any questions on this as a high-level summary of where we have been with Task 1A?

Mark Savage

Steven, quick question.

Steven Lane

Yes, Mark?

Mark Savage

So, does the slide say "assessment of plan of treatment"? Not that it really matters, but…

Steven Lane

You are absolutely right. That is the actual name of the class. So, Al, can you capture these comments? We will make that adjustment. Thank you, Mark.

Al Taylor

I think we can make that correction to the slides for HITAC if it is in there too. I will double-check.

Tasks 1b and 1c (00:06:28)

Steven Lane

Yeah, there was a timing thing where the HITAC stuff gets distributed and posted, but we will do the best we can. Anything else from our discussion to 1A that people wanted to make sure we captured here and shared back with the HITAC? I will try to watch the chat, but that is usually what Leslie is doing for me. Good morning, Andy, good morning, Brett. Minor correction – here we go. Thank you, Sasha. You are all over it. Good.

Let us go onto the next slide, which addresses how we have been approaching Task 1B – that is to say, evaluating the new data classes and elements – it probably should say "classes and elements" at the top – that were included in draft Version 2, and here, we suggested merging the diagnostic imaging narrative element into the larger diagnostic imaging report, and I know we have spent a bunch of time talking about that clarifying that scope, which is sort of the same thing, making sure that the report itself includes the narrative, but it is not exclusively the narrative so we do not lose the discrete data that appropriately belongs there in many cases. Same concept with laboratory and pathology report narratives – again, merging those together so that we are really looking at the entire report, including both discrete and narrative elements.

We did have a broad discussion about laboratory – what was included as a laboratory test. I do not think that we are quite calling this out here, but Al, we will want to be clear that there was a discussion about whether we could include cardiology, pulmonary, or sleep lab as laboratory results, and I think you clarified for us that the definition was really quite clear in terms of specimens collected from a patient and processed, so I think we will want to touch on that.

We talked about care team – we talked about the challenge of the "provider name and identifier" data elements, and wanting to change those to "care team member and identifier," and I think there has been some lively discussion about that that I have pulled forward onto the spreadsheet that we will touch on to make sure we are all on the same page. And then, we had a pretty broad discussion about "encounter time," and what that means, and how that can be used, and again, we have received some good feedback from folks on that. So, these are what have been pulled out as the high-level items related to Task 1B, but I anticipate that after our discussion today, there may be a few more that we are going to want to add in here in terms of our draft recommendations back to HITAC. Any commentary on this, other than what I have already touched on?

Grace Cordovano

Steven, I just have one minor comment about the "care team member name and identifier." I just want to make sure that the identifier – if there is not one – does not disqualify from a care team member being included and listed.

Steven Lane

Yeah, we have definitely captured that.

Andrew Truscott

That was my comment on your comment, Grace, that it should be optional, not mandatory. But also, we should make sure that we clarify the nature of the identifiers if they are being used.

Steven Lane

Yes, and we included that, including the code set and version. So, care team member ID should be optional. And then, I think there were some comments about how you make it optional. Do you say it needs to be "none" or a null value? Somebody mentioned you would need to have a date on the value. I think that is a level of detail that we are really not being asked to comment on at the implementation level, but I think these are key concepts.

Mark Savage

Steven, I had a question. Am I butting in? Sorry.

Steven Lane

No, no, Katie was helping me keep track of the hands, but everyone has been chiming in, which works fine for now.

Mark Savage

Okay. I worry that the word "remove" might create confusion at the HITAC meeting, and suggest that we should just say "merge" to make clear that we are not getting rid of it, we are keeping it.

Steven Lane

I like that. At one point, Dan had suggested perhaps we should just remove it, but I think our discussion did move past that, and I think you are right. It is more about including the narrative. I would almost use the word "include" rather than "merge," but again, Al is going to be able to make a few more adjustments, and I think one of those words would be better.

Al Taylor

So, Steven, since the changes have to be made basically immediately, I just wanted to be clear what the ask is here because the next bullet, "clarify scope of lab values and results," which would specify to include narrative components, is basically covered by almost everything that is in the previous bullet, which is to remove the narrative element. I just wanted to be clear that we are not really merging laboratory and path report narrative into lab results, we are just almost expanding the definition, finding some more specificity on the definition of "lab value results."

Steven Lane

So, in a sense, Al, I think the third bullet becomes redundant. If we just had that fourth bullet there, we could then speak to the process of our thinking and how we ended up where we did. Anything else? All right. And, on the next slide, we talk about the remaining work that we will be doing, which is continuing to refine our Task 1A and B recommendations based on continuing input both from task force members and the public, and then focusing on 1C, which I think is really going to be a meaty couple of meetings that we are going to have over the next two or three weeks, talking about which items from Level 2 should optimally be brought forward into Version 2, and why, and the prioritization of those, and the grouping or not, and then, after we make our April presentation, we will be moving on to Tasks 2 and 3, discussing the expansion process, priorities, guiding principles, and then preparing for the next cycle of submissions until there is one to be managed. So, I think we will talk about this. Leslie has prepared a slide just giving some thoughts about how we were thinking of approaching Task 3, and we will talk a bit about the prioritization that we have discussed and go from there. Michelle, your hand is up.

Michelle Schreiber

Hi, thanks. I am here evaluating the expansion process. Is that going to include a philosophic definition of what the USCDI is or a vision for that? Because I am hoping that we really press ONC or the broader community to make a determination on whether USCDI is going to be an umbrella organization for data elements across the ecosystem here or the vision of this is going to be much narrower. But, I think it is a fundamental question that we all have to understand. Thanks.

Steven Lane

I could not agree more, Michelle, and I think we have had a number of people raise this issue, and I think there are some key sub-questions in there, which is to say if a data element is included in USCDI, must it always be? Must it be made available in every certified system? I think the answer to that is yes. Must it be collected by every stakeholder to whom the USCDI applies? I think we settled on the idea that no, pediatric head circumference may not apply if you are a hospice system and that kind of thing. But, I think this notion of that guiding principles and clarification – we can certainly – and, I anticipate we will in our Phase 2 work – come up with some suggestions and guiding principles, but I am sure Al, Mike, and the team will welcome that, but I certainly do agree with the sentiment that before the next cycle begins, there is some publication that helps to put USCDI in a more understandable context for the community and the ecosystem.

Michelle Schreiber

Great, thanks.

Steven Lane

Al, do you want to add to that? I was sort of channeling you there.

Al Taylor

You are doing a pretty good job with it. I wanted to first just answer Michelle's question directly, and the answer is yes, ONC is working on just exactly that thing in scope that you asked about and Steven explained. There is more to follow, but it is definitely not just if we have all the rules set right or the criteria set right, it is bigger than that. So, yes, expect to see that before the end – sometime during the Version 3 submission cycle – to give people enough time to respond to that and possibly change their approach for Version 3 submissions.

Steven Lane

Andy, you have your hand up.

Andrew Truscott

I have. I have been patient for once. It is unusual for me. I was just going to ask whether Al et al and ONC would value this group – rather than simply saying we need to focus on core, would you value it if we said, "And, this is how we think you should look at other stuff," or should we just leave that so ONC can work that one through?

Al Taylor

The reason we added – were a little nonspecific in our tasks – some of them were very specific, but others were not specific, so we are looking for that input as well in any form, whether it is high-level philosophic, if you will, or low-level technical sorts of recommendations.

Andrew Truscott

Okay. So, Steve, it sounds like we should come up with at least vaguely what we think that structure should look like for the specialist areas of data for interoperability.

Steven Lane

Say more. What do you mean?

Andrew Truscott

It sounds like Al was actually opening the door and saying rather than just saying, "USCDI needs to focus," we could actually say, "USCDI needs to focus, and this is how you could handle other areas where you want to define data for interoperability." I am trying to stay a little bit vague in thematic areas as opposed to disease conditions or anything like that.

Steven Lane

Sure, or use cases.

Andrew Truscott

Ophthalmology will be a good one. It has found its way into the proposals right now, but actually, to my mind, it probably should not sit within USCDI, but it is an area that requires standardization.

Steven Lane

And, Andy, if you or others wake up in the middle of the night with a flash of genius, I would suggest that you capture that in the task force member recommendation spreadsheet, and then we can use that as a place to share those ideas, and then bring them forward. People have been doing a good job of that.

Andrew Truscott

I am happy to, but you know full well that flashes of genius are highly unlikely to come from me.

Steven Lane

All right, good. Is there anything else on this? I see no more hands. All right. Al, if you can, I would love you to bring up the task force recommendations tracking spreadsheet, and what I have attempted to do – and,

I invite all of you to just pull that up yourselves if you have a nice, large second screen and can just go through it – so, I have tried to make good on our promise that comments put in on individual cells will be brought forward, so what I did was I went through and reviewed the comments that people have placed on that spreadsheet and brought them forward for specific task force discussion. A number of you have been working in some small task groups on some of these thornier issues.

So, if we can look on Row 4 in the spreadsheet, which is an item originally submitted by Dan about **[inaudible] [00:20:42]** kind of treatments, as we were discussing just now – Hans, you had made the comment that US Core and CDA have items in them that fall under this umbrella, but furthermore, Mark and Dan went through and actually put together a specific recommendation, and since we do not net have it up on the Adobe meeting, I will just read it unless you want to, Mark, since you would probably give it the right intonation.

Mark Savage
Either way. I will just go for it. I recommend that –

Steven Lane
Sorry, Al. What was that?

Al Taylor
Are you not seeing the spreadsheet?

Steven Lane
We are not. We are seeing the PowerPoint, not the spreadsheet.

Al Taylor
Oh, wait. I picked the wrong screen. My bad.

Steven Lane
We understand. That is a beautiful shot of the Milky Way, unless I – sorry, others cannot see that. That is my whole screen. Al's desktop was lovely. Here it comes. You have special powers when you are co-chair. You can see what is going on and where the sausage is being made. Mark, go ahead and take us through your recommendation on Row 4.

Mark Savage
Okay. This is from Dan and me. "We recommend that 1). ONC invite stakeholders and the public to submit proposals for USCDI Version 3 that provide the range of terminology standards and code sets needed for this important data class, and 2). ONC clarify that the data element includes both assessment and plan-of-treatment detail for exchange." So, that was our recommendation. The last sentence is explanatory for the committee unless the task force wants to add it. The second point reflects that – let me back up. The reason we recommend this is because the regulation itself already defines the data element assessment and plan of treatment, so to change it would require an amendment to the regulation, which we did not think would be happening very quickly, so we pitched it as a recommendation about Version 3, which is coming up in six months.

And, the current regulation provides in the alternative – if memory serves – that it can be assessment and plan section or assessment section and plan-of-treatment section, and that second option is much more detailed, much more what we would normally think of. The first option in the regulation has very little, hence the reason for our second key part of our recommendation – to clarify that the data element includes both assessment and plan-of-treatment detail. Thanks, Steven.

Steven Lane
Thank you, Mark – and Dan in absentia – for your work on that. I know when you come back with one sentence, it can feel like "Gee, why did that take us five hours to do?", but I really appreciate the thought you gave it. Anybody have any thoughts about this, either positive or negative, in regard to whether we bring this back to the ONC or to USCDI? – HITAC, I should say.

Sasha TerMaat
This is Sasha.

Steven Lane
Thanks, Sasha. I am sorry. I know your hand was up. Go ahead.

Sasha TerMaat
No problem. I did not know if I should just jump in. So, I know that – I strongly support getting clarification. I actually did a little research on this recently and polled both some coworkers and Epic users on what they thought "assessment and plan" meant given the one-sentence definition on the USCDI website of what that data class is, and I think it is maybe to the concern that Dan raised originally that I did not get the same answer from anyone I asked. There was a huge variety in what different people thought that would refer to. So, I think clarifying is important. I am not sure that I totally understand Part 2 of the clarification that Mark and Dan have suggested. Maybe you could walk me through that again.

I guess I have a related question. As I polled people and said, "Hey, what would you think with this definition about assessment and plan from the USCDI website? What do you think that is?", a lot of things that people suggested were duplicative of other USCDI data classes. As I think Dan had even pointed out, there was a lot of duplication with progress notes, but even with other concepts like "future appointments" being potentially duplicative of "encounters," patient instructions, results, and things like that, and so, I guess part of my question was maybe philosophical. Are each of the data classes in USCDI intended to be unique, or would we expect overlap between progress notes and assessment and plan of treatment as separate data classes in that way? I know the C-CDA standard that has previously been pointed to for assessment and plan in certification is actually a notes template, though I think FHIR points to the care plan, which is also a little bit challenging as we think about what this really means.

Steven Lane
Yeah, those are great comments, Sasha, and I think it underlines the fact that this just needs more work. This needs some TLC, and I think that the way that Dan and Mark posed it as a Version 3 task is realistic. This is not something that is going to get done in time for Version 2. This needs a lot of input and thought, so I like the way this is being proposed. Does anyone have any concerns about including this in our comments back to HITAC tomorrow or next month?

Sasha TerMaat

What are we proposing with Version 2 in Part 2 of this?

Mark Savage

Steven, would you like me to walk through and explain it a little better?

Steven Lane

Sure, go ahead, Mark.

Mark Savage

Thanks for the question, Sasha. I worked off the definition in the regulation, which I think is a little bit more precise than what we find on the website for USCDI, and that may be a source of confusion or explanation. The regulatory definition of "assessment and plan of treatment" – and, I am doing this from memory – says that it is either one thing or another. It is either the assessment and plan section of C-CDA 2.1 – the standard is referenced in the regulation – or it is the assessment section and the separate plan-of-treatment section in C-CDA 2.1. I have gone through and parsed out what each of those three main sections includes, and the first one includes far, far less than the second alternative, so that is why, in Part 2 of the recommendation, we are recommending that ONC clarify that the data element actually includes all of that, and not just the small fraction that would be included in the first option in the regulatory definition. Does that help, Sasha?

Sasha TerMaat

I appreciate that. I want to dig in. When you say "the regulatory definition," was this the definition in the information-blocking regulation or in a prior reg?

Mark Savage

It is in the prior reg in the defining 2015 edition of search, where it defines – there is a definition of USCDI at that time.

Sasha TerMaat

Okay, got it, with the C-CDA templates that it points to at that time.

Mark Savage

Correct. In the definition, it mentions the standard, which is listed separately, and that is the C-CDA 2.1 template.

Sasha TerMaat

Okay, that makes sense to me. I think the only challenge I would have with your suggestion under 2, then, is that the C-CDA template pointed to by the 2015 edition is different from how HL7 has mapped US Core – the concept of assessment and plan to the care plan resource – and we would want to make sure that both FHIR and C-CDA were able to express this concept consistently for our goals to be achieved.

Mark Savage

I totally agree.

Steven Lane

Hans, you have your hand up.

Hans Buitendijk

Yes, and I would like to jump in exactly that point. It might then be helpful to clarify that the suggestion is being made, which is great, to really use that, starting with the intersection between US Core and C-CDA, and really build on that to clarify what the intent is, and then we can progress so that it also then provides the opportunity for the standards community to begin aligning based on what we are trying to achieve with these things and work on that, so that would enable that either there is clarity why both need support all or that in certain contexts, the document versus the plan of care in FHIR – that there are some variances. But, I think that second part of clarifying it would help a little bit more to really start with that intersection on what is there because that is what people are currently implementing against.

Mark Savage

So, Steven, here is an idea. If you drop the last sentence in the recommendation, which was really explanatory from Dan and me, and just build up that ONC clarified that the data element includes both assessment and plan-of-treatment data for exchange consistent with FHIR and C-CDA standards, or something like that…

Steven Lane

"Consistent with"? Is there another term?

Mark Savage

There is probably a better world.

Hans Buitendijk

"In alignment with"?

Sasha TerMaat

I think we probably want the overlap between the two, right? Where the two overlap – that is what we are aiming for.

Hans Buitendijk

And then, we can progress from there.

Mark Savage

That should not be limiting. If you think of it as a Venn diagram and you have a bunch of stuff in the FHIR section, you would not want that excluded because it was not in the overlap.

Hans Buitendijk

There is once challenge there. Currently, the requirement seems like that the data in USCDI – at this point in time, which may have changed – is expressible in both C-CDA and FHIR US Core. I think from prior discussion, we are starting to see – and, as we expand beyond the clinical data more into administrative and financial data – that that expectation will not hold up. So, in principle, I am okay with what you are saying, Mark, that it need not be that either one of them supports everything, but that is certainly not the

expectation today, so I think we need to figure out that transition in expectations so we can look at that. So, that is why perhaps aiming for the intersection between the two and aligning with that as the starting point might be the right next step, and then we continue to build from there as we clarify which construct is really used for what.

Steven Lane
Very helpful.

Mark Savage
Because we are looking at something in the recommendation for Version 3, could we not go beyond that so that we are inviting the community to perhaps take it beyond the intersection?

Sasha TerMaat
Is 2 supposed to refer to the recommendation in 1, or is 2 referring to the current state? Just to make sure I understand, are we going to include an assessment and plan in USCDI Version 2 at all, or remove it pending the recommendation that we clarify it in 3 with specific terminology standards and code sets?

Mark Savage
We are not recommending removal.

Hans Buitendijk
It already sits in USCDI Version 1, so it is already there.

Sasha TerMaat
Right, but I think, then, if it is already in Version 1 and going to be in Version 2, we cannot have certifications proceeding imminently if only one of the certification standards supports the definition that we clarify to.

Steven Lane
I do not think we are going to clarify it in Version 2. I do not think we are proposing making a substantial change because there just is not time. My understanding is these are all suggestions for Version 3.

Hans Buitendijk
Unless we clarify that there is acknowledgement that given this **[inaudible] [00:34:14]**. Correct, yes, in this context. Sorry, I was using a different definition for a moment. Yes, in this context, not a different data element.

Steven Lane
Good, all right. Denise is agreeing. Any other thoughts here? Al?

Al Taylor
So, something to consider is that until the next rulemaking cycle, health IT is going to be required to capture and exchange diagnostic imaging narrative, lab report narrative, and path report narrative as a discrete data element, and so, consider the impact of recommendation or even an action to remove that data element from a requirement when it is going to be a requirement for at least the next several years. And

so, rather than removing them, possibly to clarify the reason for the narrative, which was the same reason that we added clinical notes in the first place.

Steven Lane

I think what you are saying is that while we could make these clarifications in Version 2, systems are still working with Version 1, and until rulemaking transitions everyone to a future version that would include this clarification, systems will continue to need to deal with narratives as a discrete data element. Is that what you said?

Al Taylor

Yes. So, just consider the impact of removing something, and it basically makes conformance to V.2 impossible or difficult when the requirement is still to conform to V.1, which would include this data element that is removed in V.2.

Hans Buitendijk

Is that accurate in light of the – and now, only looking at those that actually use the standards to implement this? Because in other settings – in other initiatives, that might not play, but looking at how the standards are implemented and how the terms, attributes, and data elements are used there, we may want to consider and think about whether it is truly that much of an impact based on where and how narrative is captured, and therefore could or could not be available as part of a report or not. So, I would suggest having a look at that. I am not convinced that it would make it impossible, but it is worth looking at.

Steven Lane

Yeah, and again, I do not know that this is a point that we need to get hung up on here in the task force. We are helping to suggest the future direction, and the subtleties of how that is going to play itself out are important, and thank you for reducing them, but I do not think we are going to solve them. All right. I do not see hands up. In the interests of time, I would like to keep moving down to Row 9, where a number of people make the point which we have touched on already that under "care team member ID," it is going to be important that we embrace the idea that not all care team members will have an ID, and again, we do not have to get into the technical details on how that is going to be done, but that will be included in our recommendations, as we discussed. Anything else on that? Okay, we are looking forward to Andy's stroke of genius.

Mark Savage

Steven, I am sorry, but I just have something really quick because it is a broad comment, not just on care team member ID. The USCDI defines the requirements for capabilities of a system, not the requirements to document anything in a system by a provider.

Steven Lane

Right.

Mark Savage

And, that applies to every data element in USCDI. Practice guidelines dictate what must be documented; various guidelines dictate what must be documented. This is what a system must be capable of documenting.

Steven Lane

And, I think that will be a nice sub-point to include in that clarification of what is and is not USCDI that we are looking forward to producing. Okay, on Row 11, in the discussion of "encounter time," Mark added a further thought related to the potential benefit of studying what dates and plans are already captured in health IT systems and could be used to indicate an encounter time. It is an interesting thought, and maybe EHRA could help us out with that. I do not know whether, Sasha or Hans, you guys might want to take an action item to check in with folks to provide some input to ONC as they are thinking about how to further clarify "encounter time." Also, I will steal a little bit of Michelle's thunder. CMS has prepared some really detailed comments that they are going to be posting to the public website that also touch on this area. I think there has been a lot of good input on encounter time.

Sasha TerMaat

If we were to do a survey within EHRA, is there a list of choices to survey about current capabilities on? I do not know if that is part of a lower-level data class that we could steal from for our survey.

Steven Lane

I think that is a question to you, Al.

Al Taylor

I am trying to come up with a good answer. I think that however you – if the question or the recommendation is going to be that it should exclude a particular sort of timing and you can get that information from surveying users or surveying systems, that is fine, but I just wanted to clarify that we intentionally – we had a discussion about encounter time/encounter timing because I think the original submission was for encounter timing, but either way, it was intentionally left open to allow for a variety of different types of timing to be included because depending on the type of encounter – inpatient stay, outpatient stay, or anything in between – the time element could mean different things.

Leslie Lenert

This is Les. Does the intention define the start of the encounter or the start and the end of the encounter so that you have the whole duration of time of it? Is that what you're trying to get at with this element?

Al Taylor

ONC's original intent was to allow for the ability to capture appropriate timing related to an encounter.

Leslie Lenert

I think that if you capture the start of the encounter, you can define an episode of care. If you want to automate the process of billing based on the length of time of the encounter, that is a much more challenging issue, and as I said, the duration of an episode of care is interesting. I am not – I guess an encounter makes it easier to define what that is. Is that what we are trying to do?

Hans Buitendijk

Maybe as additional context, if you look at – if the question is asking EHRA for feedback and thoughts on time, looking at the current standard that supports this, it would indicate that those kind of discussions have effectively been occurring, that the period that has the start and end of an encounter must be able to be

supported, and we are depending on the encounter, whether it is inpatient or outpatient, that one or both are relevant, although both may not be valued at the same time, and length is certainly in the base standard there, but is not a required, supported capability in US Core at the moment. So, the extent of an outreach would be how many are expressing encounters in terms of length, but that then goes back to the prior question of what we are trying to achieve for the purposes of USCDI Version 2.

Steven Lane
Michelle, you have your hand up.

Michelle Schreiber
Hi, thanks, and thank you for having flagged this issue to begin with. I think from a CMS point of view, the ability to identify an encounter timeframe – when did something begin and end – I think that is what we are looking for, certainly for quality measures. When we define a quality measure, especially an electronic one, it sometimes is when it began and ended, and **[inaudible] [00:44:52]** different kinds of encounters, as you have all pointed out – hospital encounters, clinic encounters – so it really is the beginning time and time, and of course, you can calculate the duration from that. If we cannot define that because we do not have start and stop times, then it limits the ability to understand the care that was provided for any given process encounter **[inaudible] [00:45:25]**.

Steven Lane
So, can we ask Sasha and Hans – since Hans has already turned in all of his old homework – to take this back to EHRA and start a discussion?

Hans Buitendijk
Yes, and the comments that Michelle just made around start and end for inpatient stays – clearly, for outpatients, the question will be if the end time is always relevant.

Steven Lane
Well, it is certainly relevant to billing in the current billing process. I know now that when I code for encounters, my EHR is running a little timer in the background, and it tells me how long I am in the encounter and gives me the option of using that to select a code based on the new billing rules –

Hans Buitendijk
Which has typically been the length. That is why I am curious. But, we will follow up.

Steven Lane
Wonderful, thank you so much. No more hands. And, you can see, I hope, that in Column J there for the discussion, I have tried to throw in a few times that the EHRA might consider in their survey. All right. On Row 12 – and again, I am pushing because we still want to get to the other spreadsheet – the discussion provider role – Dan and Grace have both weighed in here. Dan is not here. His point was "The data class should add a clarifying statement about whether organizations are being specifically excluded from being represented as a care team member." I think that was a good point, and then, Grace, do you want to speak to your comment here?

Grace Cordovano

Yes. This is what I was previously mentioning. My concern from the patient and care partner perspective is that in cases where you have chronic illness, multiple comorbidities, rare disease, and disability, a lot of the care is happening outside of the traditional four walls of medicine and needs essential care partners, advocates, people who are designated as personal representatives or executives of the estate, et cetera. They will not have an identifier at this time, and I do not want that information to be excluded as a result.

Steven Lane
Any other comments on that?

Clement McDonald
Just to clarify, are you saying they should at least include their name? I think that is reasonable. Is that what you are saying?

Grace Cordovano
Yes. My concern is that they are going to be linked – the name and identifier – and if the identifier is not available, that information is not going to be entered.

Clement McDonald
Okay, I think that is a very reasonable position, so I support it.

Steven Lane
Also, Grace, I think this comment really refers to the data class as opposed to the individual data elements here, and this is just where I stuck it for convenience as I was bringing it forward, so I think that is pretty clear. All right, no hands? We are going to go on to Row 15, "encounter disposition," where we have had a pretty lively discussion. We went back and forth about whether "disposition" should only apply to hospital encounters, or also to ambulatory encounters. I sort of felt like we were coming around to embrace this idea that "disposition" was a hospital-specific concept, but Mark did some additional homework and had a countervailing opinion.

Mark Savage
Are we on Row 15, Steven?

Steven Lane
Fifteen, yes.

Mark Savage
So, my comment there was only in relation to the previous recommendation, which said the next version of US Core will include "disposition" under "hospitalization," and I was just observing that I think "encounter disposition" is broader than just "hospitalization," so I was thinking that it does not satisfy the issue just to say it is going to be included under "hospitalization" because there is more.

Steven Lane
I will just say in my experience that we do not use the term "disposition" in the ambulatory context. We will use "follow-up," "planning," or "return to clinic," so it is not a term that we are used to using. I think the term

is, as US Core has identified, more related to "hospital encounters," but what do other people think? Michelle, I think this was also in the CMS comments, as I recall.

Michelle Schreiber

It was, thank you. Do we also think this is broader than "hospitalization"? A simple example is emergency room disposition. That's considered ambulatory, not hospitalization. We know that the disposition there is important **[inaudible] [00:50:31]** granted most, but not everybody, and if we start looking at **[inaudible]** definition of this, **[inaudible]** skilled nursing facility, what is their disposition? Are they going home with homecare? Are they going back to the hospital? So, we think this does extend beyond just the hospital.

Clement McDonald

Hear, hear.

Steven Lane

All right, good. Again, I think the comment to HITAC is really to provide greater clarification. There is a lot of detail here, and thank goodness Al has been here for all of our conversation because he will help carry this forward. And then, finally on this spreadsheet, in Row 16, in "encounter location." Mark, you also had a comment on this one.

Mark Savage

Yes, and for context, this is more on the clarification side of things, not a specific recommendation. We see increasingly broad – increasingly, that care occurs in non-clinical settings, remote care virtual monitoring, et cetera, so we need to make sure that the value sets for "location" are not just limited to clinical settings and exclude those other places where encounters are occurring?

Steven Lane

Great. Again, we are not seeing that. Al, if you can scroll down one more row to "display," but we did capture that, so, thank you. If no one has anything more to add here – I see no hands up – Al, you cannot see the chat, sorry. There we go. We captured Mark's comment on Row 16. Let us flip over to the other spreadsheet, if you will – the task force member recommendation spreadsheet – and again, we are at 8:30, we have 25 minutes before public comment. My goal is to go to the 1A and B recommendations that people have included, knowing that we will come back to 1C. So, on the second spreadsheet, we start with a 1B on Row 25. Grace, you – oh.

Al Taylor

I filtered it.

Steven Lane

Oh, you filtered it, I am sorry. My bad.

Al Taylor

So, it is not the same if the first one that you wanted to talk about –

Steven Lane

No, that is fine. The row numbers changed. Okay, on the new filter, we will go to Row 7 with the 1A. These classifications by task force charge are a little arbitrary. I actually went in and changed some of them because I think some people may have misclassified them, so I will take responsibility for that, but again, this is assessment and plan of treatment, as we have been discussing. Grace, a number of your comments have to do with social determinants of health and how to bring that forward, so maybe you want to take a couple of minutes, Grace and Mark, since you are both really involved in Gravity, to set the table for this so that we do not necessarily have to go through every single item. I think most of us are aware that the Gravity Project submission of new data elements to support social determinants mostly ended up at the comment level, and a lot of people were disappointed by that, but you guys give a high level of what you are thinking here.

Grace Cordovano

Sure. Really quickly, my biggest concern from the patient and care partner perspective is a lot of the data that we are recommending or already is captured in draft V.2 is missing that critical component of what patients are really dealing with in the real world, and thus, by not capturing essential social-determinant-of-health factors that are huge barriers to patients, we are not going to be able to proactively connect them to the community support and financial assistance resources as readily because that information is not reflected here. As a newcomer, I think I would defer to Mark and the work that he has been leading, but in general, somehow creating a framework here to ensure the prioritization of social determinants of health to Level 1 or Level 2.

Steven Lane

And, just to be clear, before you speak, Mark, I think this notion of supporting a framework that will allow us to bring social determinant data elements forward into a future version of USCDI is a good way to phrase this because again, remembering that our task force's scope does not include moving things from comment into another field, but I do not want to deny us the chance to have this discussion, but again, I want to abbreviate it a little bit here today so that we end up with those elements that we can meaningfully discuss under Tasks 1A and B. Mark?

Mark Savage

Thanks, Steven. I will help in that regard by pointing out that the discussion is coming. The Gravity Project did make a recommendation for social determinants of health with two categorizations, and one of those categorizations is at L.2, so we will be able to discuss that at the appropriate time. It did not get included in draft V.2, and I and perhaps Grace will have more to say at that time. I agree that we have to be considering how to incorporate social determinants of health, and I believe the Gravity Project is building a really good way forward using FHIR V.4.

Steven Lane

That is great, all right. So, back to the spreadsheet, then. So, Row 7 has to do with how social determinants may eventually impact assessment and plan of care. Row 8 is a different thing. It is specifically about operative notes and the fact that that particular note type was not included in the core set that was included in USCDI Version 1. In draft Version 2, there was no comment about increasing the number of note types. In fact, some of the note types got shifted off into other data classes, but we have heard this from both Leslie and Grace, and I guess the question for the task force is does anybody – or, anyone else besides

Grace – feel that we should or should not suggest to HITAC that they suggest to ONC that we pull operative notes into the clinical notes to be included in USCDI Version 2?

Mark Savage

This is Mark. I support the recommendation.

Clement McDonald

I am not clear. Are you saying we should include them or not include them? I thought they had been in there.

Steven Lane

They are not. USCDI Version 1 includes procedure notes, but not operative notes.

Clement McDonald

Is that a difference?

Steven Lane

It is a difference. They are different LOINC codes, they are different things. I know our organization went through a whole deep dive on this. We actually decided to include operative notes in our releases for information blocking, but other organizations have not. There are issues around risk, and surgeons, and malpractice – a lot of surgeons would probably prefer that their operative notes not be read by their patients, but some might. So, this is a specific recommendation to add operative notes and the associated LOINC code to the list of note types that are shared under USCDI.

Clement McDonald

Okay, but I would suggest we at least put in "surgical notes" as a synonym or hint so that is what you are talking about.

Steven Lane

Okay, but it sounds like you support it, Clem.

Clement McDonald

Yeah, I do.

Steven Lane

Okay. Does anybody else want to speak one way or the other? If it is just more support, that is fine. Does anybody feel differently? Does anybody feel it is a bad idea?

Hans Buitendijk

This is Hans. Just a question clarifying – the term "operative note" is used at a document level and it is used at the individual note level. Which one are we talking about here, the full document as an operative note or the operative note as the narrative? A similar kind of conversation, perhaps, as some of the other notes/documents/narrative discussions.

Sasha TerMaat

Perhaps "surgical report."

Steven Lane

Well, I think we will need to reference the LOINC definitions, right? Do you have a feeling one way or the other, Hans? Do you have a preference?

Hans Buitendijk

I have a feeling, not yet a preference, but the feeling is that if it is about the operative notes narrative, it is more likely already in a number of different documents in play. If it is operative report, if you will, just to use that term to distinguish the two, the question is how wide it is because that is a document type that is currently not one of the ones that C-CDA document types in the list of regulatory references where it is included. That is where I have a feeling, and that requires a little bit of follow-up depending on what the intent is.

Steven Lane

I think the intent – this was brought forward by people representing patients and caregivers, so I think the intent is to get the operative report, as dictated or otherwise documented by the operating surgeon, in the hands of the patient. That sounds to me like we are talking about the narrative, and it sounds like the issue of note types and where that narrative is included is probably not key to the intended use case.

Al Taylor

Steve, could I make a comment?

Steven Lane

Al.

Al Taylor

I just wanted to point out the fact that "operative note" was not submitted for Version 2.

Steven Lane

Ah, that is right. I think we heard that earlier. Good point. We cannot do this anyway. It is out of scope. Thank you! We will work on that next time. Moving on.

Al Taylor

However, we are including it in recommendations for Version 3.

Clement McDonald

Well, just one more clarification. In FHIR, "procedure" is defined as something invasive, but I guess it could be those little things you do at the bedside, so I think it might be inclusive of surgical notes in some people's minds.

Steven Lane

Yeah, and those people would be confused because LOINC differentiates them.

Clement McDonald

Oh, okay. LOINC has to be right, right?

Steven Lane

Well, it is what ONC is pointing to. The fact that this was not yet suggested or was not suggested prior to the Version 2 deadline takes this off the table. Sorry about that, Grace. And, let us move on and cover as much of these as we can. Grace, the next one was immunizations.

Mark Savage

Steven, can I just throw out a point on the previous one, please?

Steven Lane

Sure.

Mark Savage

To Hans's point, which is that the narrative might already be included in other places, I think it is worth checking to see if it is already included in some way under a different name under the current USCDI or what has been submitted for L.2 or V.2 because then, it might not be off the table. I do not know the answer, I am just flagging the question.

Hans Buitendijk

The place that I am checking is the CCD definition. If it is anywhere, that is where I suspect it is, but I do not know off the top of my head.

Steven Lane

Okay. Grace, were you going to say something?

Grace Cordovano

The same thing about immunizations – I think that was not originally submitted, but I was reacting more to the COVID-19 pandemic and how we could not have foreseen that needing to be submitted, so I just wanted to be mindful of time for Line 9.

Steven Lane

That is a good point, and I think there are a few of these that will have similar. The next one – Sheryl, your name is on this along with Mark on Row 10 related to consent, "Include social determinants of health, data class, for various use cases." Here again, I think – Mark, can you just clarify which of the Gravity Project proposal data elements was included in Level 2?

Mark Savage

First of all, I am not sure if this should be a 1A or a 1C. I contemplated –

Steven Lane

Yeah, it is probably a 1C at the end, right?

Mark Savage

Yes, that was my guess, but I did not want to change anything that Sheryl had indicated. To your question, we both submitted social determinants of health by subject area, like food insecurity or housing instability, and we submitted it organized by activity, like assessment, goal, health concern. That latter organization of the same subject data elements was included as L.2, but was not included in draft V.2.

Steven Lane
I am sorry, what was that again? Which one, Mark?

Mark Savage
The version that organizes it by activity, like assessment, health concern, problem, intervention, goal – that was included. Not data class – social determinant of health. That was listed as Level 2.

Steven Lane
Okay, great.

Al Taylor
The consent data element actually was determined a comment level because of a couple different reasons, but that was one of the six data elements that were submitted from the Part 2 submission from Gravity, and we actually did – that consent is actually a comment-level data element this time around.

Steven Lane
Therefore, this becomes a Task 3 item, not a 1A item, so again, I apologize for that. Moving right along, goals on Row 11 – again, related to SDOH data class. I think this is similarly going to be now part of Task 3, correct?

Mark Savage
I am guessing this is 1C, Steven.

Steven Lane
1C, because it is…?

Mark Savage
Level 2.

Steven Lane
Okay, because this one is in Level 2. Okay, got it. I have to get my colors right. And then, on Row 12, we had laboratory units of measure. Here again, I think this is just one that was not submitted. Is that not right, Al? I know a number of people have pointed this out – or, do we consider this to be included under "laboratory results" already? I know Clem has commented on this.

Al Taylor
Sorry. Yeah, units of measure is a standard, not a **[inaudible] [01:07:12]**. That is the way t express a laboratory result, or other things as well. It is going **[inaudible]** as well, but the "units of measure" was basically incorporated – really considered part of the "laboratory results" section, but it was not specified as an applicable standard because within its – representing lab results for values with LOINC, SNOMED, and

UCUM are all appropriate depending on the setting, and so, "units of measure" was not added as a separate data element. I feel like it is more of an applicable standard within **[inaudible]**.

Clement McDonald
The problem, though, is that nowhere is it asserted now – although it was in an earlier version – that UCUM is what you would use for units of measure when it was a quantity, except you do assert it for vital signs, and of course, it is also asserted in CDA, FHIR, DICOM, and IEEE.

Grace Cordovano
I would just add if we can add that to Page 9 just to clarify – where "values and results" is described, to make a note of that so it is crystal clear.

Steven Lane
Sorry, you said Page 9?

Grace Cordovano
I am looking at the draft.

Steven Lane
Oh, okay. All right, I think this sounds like something that we could and should bring forward in our comments to HITAC. Is that correct?

Clement McDonald
Yes – at least, from my perspective.

Steven Lane
I can touch on it in our comments tomorrow, and then we can refine it before our April submission. All right, great. Moving on, that was what had been sorted initially as 1As. The 1Bs – Grace, you are on a roll here. Date of resolution – do you want to comment on that briefly?

Grace Cordovano
This was one thing that really jumped out as a grave concern from a documentation standpoint. So, first of all, the date of resolution is not broadly applicable in my comments to people living with chronic illness, life-altering/life-limiting conditions, disability or rare disease, terminal illness, and even active-death and end-of-life care. So, if, God forbid, there should be some type of data element that has a vagueness in documentation, such as date of resolution, and then it is incorrectly documented, it can have severe, negative, potentially irreversible impacts to patients and their families on matters such as disability benefits, and as you may or may not know, to overturn that type of a decision is an extremely heavy lift, so I really encourage the task force to consider highly removing this element at this time.

Clement McDonald
I – go ahead.

Steven Lane
No, you go, Clem.

Clement McDonald

I support that because it is a difficult thing. The records are not maintained well, and you have different practitioners saying different things, so they do not want to touch the other guy's problems, so you end up with a whole lot of stuff that might be resolved, but it is still hanging in there, so it is a tough problem, not to mention a problem with the harm it might do.

Steven Lane

So, again, I do not mean to be defensive at all, but as the submitter of this element, I see it a little bit differently, and we had a nice opportunity to talk to HL7 about this just yesterday. Thank you, Deedee and others, for facilitating that. Again, I think the idea of these date fields associated with problems is really simply to make them available – not to require their population, but to have certified systems make them available. "Date of resolution," unlike "date of onset" and "date of diagnosis," was not specifically driven by the use case that led to this submission. Al, I think this was actually your suggestion to add this in to make a complete set for this data class, and I appreciate the challenge. Again, as a provider that would populate this field, I get it, and I would do it, but a lot of people tell me that my documentation is a little different than the average physician's. Al, do you want to give some perspective on why you thought this should be added?

Al Taylor

I think the reason I recommended adding it is to create a matched set as far as "date of resolution." I think "date of onset"/"date of resolution" is a matched set. Clearly, sometimes it is difficult to determine either one, but it helps a lot with problem list management, and Grace, to your point, if people feel like there is some pressure to put something in "date of resolution" that takes them out of – so that providers are no longer considering management of a problem that has a date of resolution on it already entered. That is a valid point, but Steven's point about not being required and possibly the assumption that an empty field for "date of resolution" is equivalent to "current." I know it is not true all the time, but there is that possible way to indicate an acting problem.

Steven Lane

Denise?

Denise Webb

Yes, thank you. Grace, I really appreciate the concerns you had expressed, but I want to share the flip side of that, which was referenced. So, if the problem list does not have some indication of date of resolution, it can also impact – for example, I will take myself. I am a commercial pilot, and I do have to provide some records periodically to the FAA, and it causes me great problems getting my medical certificate when there is no indication that something on my problem list was resolved or addressed, and then they end up penalizing and requiring you to have additional doctor's visits and provide more medical records, so it has been a huge problem. And then, the safety side of it, too – I have seen things on the problem list that are not even accurate or were suspected, and it appears it is a problem, and there is no date of resolution or that it was addressed, so I just want to give that other perspective.

Steven Lane

Jim?

Jim Jirjis

Hey, Jim Jirjis here. In listening to all this, one thing I would offer is my initial thoughts were "Hey, it is not required," so I get that if we provide the ability, then for certain use cases, it is present to allow machine-understandable termination. My only concern is the likelihood of it actually being correct, and the reason I would vote to not have it in there is because I do not know if we have enough data that when people do use the field, do we end up more often than not with data that is not correct or has to be validated – Denise – anyway by going into the records? These are tricky issues, and from my perch, that introduces noise that, in my opinion, is more likely to be inaccurate than it is to be valuable, and there are other ways to solve the problem. Would that be sufficient – a data field that is resolved for getting a **[inaudible] [01:15:55]** fact – or is it going to require something more than that? So, my vote would be that it is unlikely to be useful when populated, and, in fact, maybe misleading, so I would vote to remove.

Steven Lane

Mark?

Mark Savage

Yes. Just an observation that date of resolution is really tied to the definition of the problem. In my experience, problems are broadly defined, so I think a date of resolution would tend to suggest that all of that broadly defined problem is solved where, listening to Grace's description of issues, perhaps only a piece of it is, so I am just noting how important it is to connect the date of resolution to the granularity of the defined problem.

Steven Lane

All right. This has been really helpful. I do not think we are going to make a decision. We are about to go to public comment. I will do my best to capture what we have been able to get through of this spreadsheet today, and we will come back to this and carry on at our next meeting. Let us go to public comment.

Public Comment (01:17:11)

Michael Berry

All right, thank you, Steven. Operator, can we please open up the line for public comments?

Operator

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

Steven Lane

Grace, we see your hand up. You will be the first voice when we finish public comment.

Operator

There are no comments at this time.

Steven Lane

Thank you so much. And again, I will take a moment – so, maybe not the first voice – I will take a moment again to encourage members of the public who are joining us to not be shy. We really look forward to comments from the public, and please think about offering them in future meetings. Grace?

Grace Cordovano
If I may, I wanted to have an additional follow-up comment on the discussion on the resolution, and then I can certainly appreciate both sides of the coin and how important it is in many circumstances to have that endpoint proving that there is resolution and health reinstated. I want to point out that in those cases, while it is an additional step, there are other points, classes, elements, and pieces of data that can be generated to prove resolution. On the opposite side – which is, from my perspective, the most challenging – if there is vagueness or an incorrect documentation in that field, it would require patients to go through the addendum process, which is very vague, it is not robust, and it is very challenging to have anything that is incorrect overturned as an acceptable or recognized addendum, so I just want the task force to also be mindful of that process, that it is a barrier in more circumstances than one.

Steven Lane
Thank you. I will note – and, I think we may be moving toward the consensus to remove this – that there was another problem-associated date included in V.2 – or, Level 2 – that was not proposed for draft V.2, which was the date of onset, and I personally feel that having date of diagnosis without date of onset creates confusion, which we have heard here in our discussions and which we also heard at the HL7 meeting yesterday, so I think especially if we were going to suggest holding off on date of resolution that we at least consider including "date of onset" along with "date of diagnosis" because I think that makes it much clearer to users. It is an easier story to tell. If you only have one of those, then I would posit more people are more likely to use it incorrectly. Any comments on what I just said, any feedback on that? All right. The next one, on Row 14 – we will just keep blasting away for one more minute here – was clinical notes, narrative section for path and diagnosis reports – Grace, was there something different here than what we have talked about before?

Grace Cordovano
No, I think this has been rectified and addressed.

Steven Lane
Okay. Do you mind if I delete the row altogether?

Grace Cordovano
That is fine.

Steven Lane
Good, all right. That brings us just about to the hour. Let me see. Hans, you have the next one. You actually put a lot of thought into this about "encounter diagnosis." I would invite people to go back to the editable spreadsheet to what is now Row 14, an item that Hans included, and talking about "encounter diagnosis" – I think that is a lot like "encounter time." There is a lot of potential devil in those details, and we will pick up our discussion there when we meet again. I think this brings us to the end of our 90 minutes together. Does anyone have any closing comments or questions?

Clement McDonald

Yeah. I would like to compliment you and Grace on getting through these agendas. This has not always happened in the history of all the HITAC meetings, so you guys get some gold stars for all this.

Steven Lane

Thank you, Clem. Your comments are most appreciated.

Mark Savage

Steven, can I just place appreciation for what you are about to undertake tomorrow, which is to carry forward all of this detail in such a succinct way that all of the HITAC members easily understand it? Thank you so much.

Steven Lane

From your mouth to God's ears. I have to tell you, the HITAC is a great place – really good people, very thoughtful, very friendly, and we are hoping to get some guidance from Micky, and I look forward to representing all of you there. See you next week.

Clement McDonald

Mark, do not put pressure on him.

Steven Lane

Bye-bye.

Adjourn (01:22:59)